Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Carlina Rozo Chen November 15, 2008 2:55 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 11507 Lovejoy Street Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🗓 F Director 103-28-2367 90 Oct. 4, 1918 Colombia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1 ☐ Yes 2 INO Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11507 Lovejoy Street 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 0, 1 ☐ Never Married 2 ☐ Married 2 🔀 No Maryland 21215-0036 Colombian 1≹Yes 2□No Specify. \$ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If Item 27 is marked other that any injury or other traumatic event, Item once. Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alejandrino Rozo Isabel Gaitan ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11507 Lovejoy Street, Silver Spring, MD 20902 Theresa M. Chen/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov. 22, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, schock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ∐Yes 2. No o been signed by the should be detached 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate his completely filled in by the funeral director, page performed? Yes 2 No 1 ☐ Yes 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

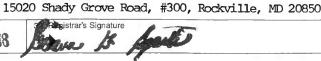
State

10

Aimee Seidman, MD
31. Date filed (Month, Day, Year)

NOV 18 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D37801

November 17, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Maryland / Department of Health and Mental Hygiene 2 | amend #5 Per FH G887 1/09/09 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11 Month **Physician** 200 Harold M. Cole 2008 7:35PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worchester 9. Birthplace (State or Foreign 5. Social Security Nu6632 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 05-03-1913 Months Days Hours 1√ M 2□ F 218-34-6617 95 Pennsylvania Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it has Madical Event and be notified at once. 1 ☐ Yes 2 ☐ No Director MD Worchester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Meadow Street, Apt. 112 21811 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 □Yes 2 □ No Specify: Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) USPS Chief Financial Examiner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis J. Cole, Jr. Josephine Shorb ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bethyl W. Cole, wife Meadow St., 112, Apt. <u>Berlin, MD 21811</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Ignatius Cem. 11-24-08 Orrtanna, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. L. Davis Funeral Home 21. Signature of Funeral Service Licensee Les Dovis 12525 Bradbury Ave Smithsburg, MD 21783 23a. Part Entermease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Medical Certification: To

The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the upon to be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-tran 632 Records, P.O. Box 68760, 8-34-6

Harold

DOB 05/c3/ru3DOD 11/30/08 at 1939 Baltimore, Maryland 21215-0036

05/03/193

Physician

/Medical

Examiner

			1 Yes 2	No 3☐ Probably 4 X Unknown
			24a. Was an autopsy performed? 1 □ Yes 2 ⋈ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □Yo
25. Was case referred to medical		26. Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 ZNo	Hospital: 1 Dunpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Hon	me 5 ☐ Residence 6	☐ Other (Specify)
27. Manner of Death 1		28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		tory, office 2	28f. Location (Street and City or Town, State)	i Number or Rural Route Number,
	The second secon			

29a. Certifier

(SertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 0064120 29d. Date signed (Month, Day, Year) 11/21/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, D

Berlin MD 21811 Health way Drive IF 31. Date filed (Month, Day, Year)

State Registrar

DEC 03 2008

Registrar DHMH 17 Rev 1/2001 Victare

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

2008

OCINE OCME

219 S. WASHINGTON ST., EASTON, MD 21601

			State of Maryland / Dep For State Registrar State of Maryland / Dep	artment of Health and rtificate of Death		Reg. No.	2008	38504
	5 2		1. Decedent's Name (First, Middle, Last)		2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Sandra Christine Donaty		Nov. 1		800	2:34 AM
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	ath		County of Death	
		36	Anne Arundel Medical Center	Annapolis If Under 1 Year If Under 24 H	rs. 8. Date of Bir		ne Aruno	
	Funeral		5. Social Security Number 2.1 / 1 − 5.2 − 3.9.7.3 6. Sex 1 □ M 2 ☒ F 6. Sex 7. Age (In yrs. last birthda) Yrs.	Months Days Hours Mi	in. (Month, Da	ı <i>y</i> , Yea <i>r)</i>		place (State or Foreign ntry)
6	Director		214-52-3973 62		May 27	, 194	o wası	nington, DC
	land ow it		10a. State 10b. County 10c. City, Town or L	ocation				10d. Inside City Limits
	Mary -f sh	tor	Maryland Prince George's Glenn Dal	e				1 X Yes 2 No
	r 28a	Director	10e. Street and Number	10f. Zip Code		10g. Citize	en of What Cou	ntry?
	h with	al D	6507 Facchina Lane	20769		U.S.A	Α.	
	deat r.mu	Funeral	11, Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.))- 1	 Race - American Black, White, 	
o o	after or ite	/Fu	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☑ No Specify:		1	Specify: T.Th.	i + 0
3	ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	and any and Commention		16h Kin	W II.	ite
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V	ould be filed within 72 hours after death with the Maryland Mertal Hygiene. Arked other than "natural" or items 23a or 28a-f show afte event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker		Own	n Home	
У С	filled Hygi sther ent, t	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's N	lame (First, Middle	, Maiden S	Surname)	
2	ld be ental ked c	To B	Joseph Robert Hysan	Virgin	ia Louise	e Cum	mings	
5	shou ind M s mar umat	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or	Rural Route Numb	oer, City or	Town, State, Zi	p Code)
Š	and 2 alth a 27 is		Frank J. Donaty, Jr. / Husband 6507	Facchina Lane,				
ກົ	ss 1 ss of He item		20h Place of Displace of Displ	position (Name of ematory or other place)	Date	20c. Loc	cation - City or T	own, State
Ĕ	Page nent ant: II		4 □ Donation 5 □ Other (Specify) Fort Lin	coln Cemetery 11,	/20/2008	Bren	twood,	Maryland
Dallillion	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21, digitatore of Furnian Sci. viso 200/000	22. Name and Address of Facility		4739	9 Balti	more Avenue
_	20 E # 9			asch's Funeral H			ttsville	Approximate
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`	Physician		Immediate Cause (Final disease or condition resulting in death) A Hypercarbic Respiration as Hypercarbic Respirations of the second resulting in death)	ratory Failure				
	/Medical Examiner		Due to (or as a consequence or).					
		E.	Sequentially list conditions, Due to for as a consequence of:					
	uted insit	Ē	ll ary, leading to immediate pue to lor as a consequence of: cause. Enter Underlying Cause (Disease or injury					
,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last C					
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0		ledi						
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	ed for	Physician/M	1 L Yes 2 No g□ linknown	Other (specify)			WOTET	Day Tour
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cords	requi	ted						
e S	2 2 2	Completed	Acute Renal Failure		— 24a. Wa:	s an opsy formed?	prior to c	topsy findings available completion of cause of
la	ician: The certificate ha ector, page				1□ Yes	2⊠No	1 ☐ Yes	2□ No
		Be	25. Was case referred to medical examiner? 1 □ Yes 2⊠ No Hospital: 1 ☒ Inpatient 2 □ ER/Outpat	Othor	Death <i>Check onl</i>		DO44-1 (0	-14.1
ō		은 -	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe			шу)
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UIVISION	Atten r deat sctor	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm,	street, factory, office	28f. Location	(Street and	d Number or Ru	ral Route Number,
5	al or after	Certification:	4 Homicide determined building, etc. (Specify)		City of Ti	own, State)	,	
	ospit hours uners		29a. Certifier (Check only (C	eath occurred at the time, date and p	lace, and due to the	e cause(s) e, date and	and manner as	stated. to the cause(s)
	To the Hospital or Attend, within 24 hours after death. To the Funeral Director; A completely filled in by the fi	ledical	one) and manner stated.	29c, License number			te signed (Month	
	with or no	Σ	29b. Signature and title of certifier	103744	5	17/	17/10	UR.
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K	- 5		30. Name and address of person who completed cause of death (Item 23a) (Type	Mich Hir	Honz	auli	s. Inr.	7
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	5	/	1	J	
	Regist	rar	NOV 1 9 2008 Reserve to 19					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of	Marylan	_	artmen rtificate			and M		jiene leg. No.	2008	38505
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	Examir	er	· ·		, give street and numb					Location o	of Death		1	County of Deat	
			Anne Aru 5. Social Security N		edical Cent		last birthday)	An:	napo 1 Year	lis If Under	24 Hrs.	8 Date of Birth		ne Arur	
	Funeral Director		153-28-7		1□M 2⊠F	7		Months	Days	Hours		8. Date of Birth (Month, Day August			hplace (State or Foreign untry) SSOUTI
			Usual Residence of				<u> </u>				14	august	10,1	73/ 111	_550ULT
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	8a-f s	Director	MD		e George's				Bowi	e 					1⊠Yes 2 No
	vith th	Ē	10e. Street and Nui		- 1			10f. Zip				1	10g. Citiz	en of What Co	untry?
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21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Evaninar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		Armed Force	es? 【] No		was Deced If Yes, spec 1 □ Yes 2			n, Puerto F	cify Yes or No- lican, etc.)		4. Race - Ame Black, White Specify: Whi	e, etc.
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and	be fil	Be	17. Father's Name William									<i>(First, Middle, I</i> Fontain		iurname)	
Maryland	12 should be filed within in and Menial Hygiene. 7 Is marked other than "traumatic event, the Menial fraumatic event".	2					10h Mailin		(Ctro et e					T C4-4	7 O - d -)
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	f Health tem 27 other to		20a. Method of Dis		/ Decase	20b. F	Place of Dispo	sition (Nan	ne of	- 1	Da			ation - City or	Town, State
e E	Pages ment of hant if ite			☐ Cremation 5 ☐ Other (S _F	3 Removal from Sta		surrec				11/2	2/2008	Cli	nton. N	Maryland
Baltimore,	permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any injury or other trau		21. Signature of Fu			<u> </u>	22	2. Name an	d Addres	s of Facilit	y Beal	ll Fune Bowie,	ral	Home	
			23a. Part 1 Enter t	the disease, or	complications that cau	ed the deat								20713	Approximate Interval Between
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Ö,	be exection a	Ě	resulting in death)	Last	Due to (or	as a conseq	uence of):								
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O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	months?		th 2☐ Feta nt at time of o	al death 3	⊒ Ectopic pi ⊒ Other (sp					23	3d. Date of del	ivery Day Year
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Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6	I Zee. Place of	Injury - At ho , etc. <i>(Speci</i> i	ome, farm, str fy)	eet, factory	office		2	8f. Location (S. City or Town	treet and n, State)	Number or Ru	iral Route Number,
	To the Hospital within 24 hours of To the Funeral Completely filled	Medical (29a. Certifier (Check only one)	© Certifyin 2 Medical I	g Physician: To the be Examiner: On the bas and manne	is of examina	owledge, deat ation and/or ir	h occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, a	and due to the ded at the time, o	cause(s)	and manner as place, and due	s stated. to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and	title of certifier	Pople	Age	8ëy		License		7/			signed (Mont)	n, Day, Year)
	6		30. Name and add		who completed cause		n 23a) (Type,	Print)	1110	nc					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Janet. Esham Month Anne 11 --2008 2:18 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wico. mico Salisbury Coestal Hospice at the Lake If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7, Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2 🕱 F Months Days Hours Min 220-26-7820 Director 75 12/13/1932 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "netural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 134 Liberty Way 21826 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: \$ white 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) transcriptionist medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked William Tull Mary Catherine Gordy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 405 Pamela Dr., Salisbury, MD 21804 Bonnie Smith/daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition WicompcomMemoralae 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/19/08 4 ☐ Donation 5 ☐ Other (Specify) Park Salisbury, MD Signature of Funeral Service Licensee 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 (hommon) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Kiewren my eco /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Diverto (or as a con sequence of) The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 🔀 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 29505 11-15-2008 80. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 21801 31. Date filed (Month, Day, Year) 32, Registrar's Signature State NOV 1 7 2008 Registrar

DHMH 17 Rev 1/2001

Kelvin Antonio Franklin

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State of Maryland / Department of Health and Mental Hygiene

2008 38507

		Registrar Amend#15.PerFHPGC11-17-0827##icate of	Death	Reg.	No.	
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ledical Exami	ner	Kelvin Antonio Franklin	No No	onth D vember 7	, 2008 Year	0816 hrs
			b. City, Town, or Location of Death		4c. County of Death	
		4111 Pennsylvania Avenue	Suitland		Prince George'	S
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. E	Date of Birth (MM/DD/YYYY) 9. Birth	place (State or
Director		220-25-7613 Male - 23	The second secon		14,1985 Foreign	Maryland
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any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
<u>*</u>		Md Prince George Upper Mar				1 Yes 2 X No
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Mary 28a-	Director	10e. Street and Number	10f. Zip Code		Citizen of What Count USA	ry?
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5-0036 iled within 72 Hygiene. I other than	Compl	17. Father's Name (First, Middle, Last)	18.Mother's Name (First	, Middle, Mai	iden Surname)	
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MD 21215-0036 4.2 should be filed within 72 hours after death with the Maryland thin and Montal Hygiene a 77 is marked other than "natural", or items 23a or 28a-f she unnatic event, the Medical Examiner must be notified at once			Cheryl Dr.Upper			
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JOFE ages 1 nt of H at: If i		1 Burial 2 XCremation 3 Removal from State Riverdal	e Pk Crem Nov,15	5 08k	iverdale.	Marvland
timen trant		4 Donation 5 Other Specify:				
Baltimore, permit. Pages I and Department of Heal Important: If iter		21. Signature of Funeral Service Ucensee 22. N	ame and Address of Facility rone J. Young 7	10 1/2	nnedy c+	20011 NW WashDo
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Physician /Modical		23a. Part I Enter the disease, or complications that caused the death. Do not enter the fail re. List only one each line.	ie mode of dying, such as cardiac of resp	iratory arrest	r, snock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a. Sunshot Wound of Head				Death
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Division of Vital Records, rate or Attending Physician: The law requirater death. After this certificate has been seled in by the funeral director, page 2 should the	چ	27. Manner of Death 28a. Date of Injury 28b. Time of Injury Natural 5 Ponding FOUND: FOUND:	- Subi	Describe hor iect shot	w injury occurred	
ior ttend leath tor:	aţic	1 Natural 5 Pending FOUND: Nov 7, 2008 POUND: 0812 hrs	1 Yes 2 No	, 50. 0.100		
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Division of Vital Records, P.O. Box 6 within 24 hours after death ceremin 24 hours after death. The the Funeral Director. After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for use	Certification:	4 Homicide determined (Specify) Cemetery	4111	or Town, Star Pennsylva	te) FOUND inia Avenue, Suitlan	d, MD
Hosi 24 hc Func tely f		29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occur				
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigat				
To To con	ğ	29b. Signature and Title of certifier	29c. License number	1	29d. Date signed (Mon	th, Day, Year)
6			O.C.M.E.		November 8, 200	8
5		20 None and of the formation of the 10 the 20				
OCME		Name and ad s of erson who completed cause of death (Item 23a) Mary G. Topple MD. Deputy Chief Medical Examiner 111	Penn Street Baltimore MD 2	1201		
			TOTAL OLICER, DAIGHTOIE, MD 2	1201		
St Regis						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiené U

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Michael Brian Fitzgerald November 14, 2008 7:10 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery 3212 Spartan Road, Apt. 30 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours M 2□F Yrs. 117-30-2046 Nov. 5, 1939 Director New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Deperiment of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinal must be multiled at once. 1 ☐ Yes 2 X No Director Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3212 Spartan Road, Apt. 30 20832 HSA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1% Yes 2 No If Yes, Give Korean Year or Dates: Conflict Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Katherine Rose Burke Thomas Joseph Fitzgerald 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Havener/Sister 3212 Spartan Road, Apt. 30, Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 18 1 Surial 2 Cremation 3 Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2008 Rockville, Maryland 21. Signatural Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 cert Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MaligNAWT Physician Melanoma disease or condition resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760. ettending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ormed? 212 No 1 Yes of or Attending Physician: after death. | Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and filance, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 39190 November 14,2008 10 30. Nam and address of person who completed Joseph Garrett Reilly, MD d cause of eath (Item 23a) (Type, Print) 3418 Olandwood Court, Olney, MD 20832 31. Date filed (Month, Day, Year) Registrar's Signature State 18 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 12, 2008 P^{M} Joseph A. Fertitta 9:29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House-Montgomery Hospice Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Months Days 1**₹** M 2 □ F Hours 84 428-22-4100 Jan 11, **Director** 1924 Alabama Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits show 10c. City. Town or Location other traumatic event, the Medical Exteniner must be notified at Director 1 X Yes 2 No Maryland Montgomery 28a-f Gaithersburg 10e. Street and Number 10g. Citizen of What Country? natural", or items 23a or 16 Cornerwood Court 20878-1904 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant of Health and Marked other than "natural", or items 23 ant: If item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 XYSS 2 □ No World Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: War II 1 ∐Yes 2 🔀 No Specify: White Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Geological Analyst U.S. Mapping Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Fertitta Gertrude Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 708 Hope Lane, Gaithersburg, MD 20878 John L. Clark (Caregiver) 20b. Place of Disposition (Name of Strengter), crematory or other place)
Cemetery
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State November 4 Donation 5/DOther (Specify) 17, 2008 Gaithersburg, Maryland 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Funeral Service Liberses 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Pirt 1. Enter the discase, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedial Carse (Final disease or condition resulting in death) **Physician** B-Cell Lymphoma /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Lung Cancer sician and burial-trans Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 😾 No 1 ☐ Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

Box 68760. P.0. Records, of Vital Division Hospital

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral C completely filled

50+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne T. Kouatchou, M.D., 201 E. University Parkway, Baltimore, MD 21218 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

(Check only one)

29b. Signature and title of certifier



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

20063748

29d. Date signed (Month, Day, Year)

November 13, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 9:44 AM GILPIN **Physician** MAE 80 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomer Bethoson HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 💢 F Months Days Hours 26.112 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Mulcal Evaluation into the bundled any once. Washington **Funeral Director** 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9th St NW 2001 7442 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) warehouse line worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gwendolyn NIECE 20012 Washington DC 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) heaspeake Crematory 11-24-08 | Seltsville mu 22. Name and Address of Ficility 1. Sanders Sons Mortuary Beltsville mD 21. Signature Juneral Service Licens Kincannon Lorton VA Approximate Interval Between Onset and Death 3a. Part 1. Enter the disease, or conshock, or heart failure. List only nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 1 ☐Yes 2 ☐No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of no completed cause of death (Item 23a) (Type, Print) Gerssetown Road Bethessa md 20814

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	M OF E	In yrs. last bi	Mo	Under 1 Yea onths Day		1. (N	ate of Birth fonth, Day, Yo		9. Birth	nplace (State or Foreigr untry)
00 cedent		90	Yrs.			μ ar	1 29,]	L918	Guy	ana, S.A.
b. County	1	Oc. City, Tov	vn or Location	on						10d. Inside City Limits
				Wa	shington					1⊠Yes 2□No
			1	Of. Zip Code			10g	. Citizen of V	What Cou	untry?
dan Stre	et, NW				20011				US	Δ
	2. Was Decedent Ev	er in U.S.	13. Was		f Hispanic Origin? (uban, Mexican, Pue	Specify Y	es or No-		e - Amer	ican Indian,
2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No			s, speciny Ci Yes 2MEN		rπo Rican	, etc.)		ck, White	e, etc.
Divorced	If Yes, Give Year or Dates:		יטי	Yes 21_1 N	lo Specify:			Specify	': В	lack
Decedent's Educ	ation	168	a. Decedent'		cupation ne during most of w	orkina	16	b. Kind of B	usiness/l	ndustry
y (0-12)	College (1-4or 5+)		life. DO f	VOT use reti	ired)					
	2+		Er	nginee	T	/=-			vate	
(, Middle, Last)					18. Mother's Na			iden Surnan	ne)	
Greene					_		Reid			·
Relationship <i>(Typ</i> ene (Da	ughter)				et and Number or F Street N					
on		20b. Place o	of Disposition	n (Name of	place)	Date	20	c. Location -	City or 7	Γown, State
remation 3 □Re]Other (<i>Specify)</i>	emoval from State	Arden			L .	24/20	108 н	anove:	r. M	aryland
I Service License	60_				dress of Facility	atim	ore Fu	neral	Ser	vices, P.A.
rin m	alemon	20)			apolis Ro					
sease, or compli	eations that caused the cause on each line	ne death. Do	not enter th	ne mode of d	lying, such as cardi	ac or resp	oiratory arrest	,		Approximate Interval Between
ure. List only on	Human	Nio.			ha Cop	alle	√ 9			Onset and Death
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g y	astron	selin	nism	Coro	lio vaso	ul	n de	Saus	0.	
C.	Due to (or as a	consequence	e or):	1						
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3. Time of Deat

State Registrar

To the Hospital or within 24 hours a To the Funeral L Certification:

Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

(Month, Day, Year) 1 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Hoover R. Goffin 12:00 P.M November 14, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hebrew Home of Greater Washington Montgomery Rockville 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Months Hours Director 005-12-0126 June 2, 1917 Maine Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Director 1 √ Yes 2 □ No Florida | Palm Beach Delray Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 15054 Ashland Way C-77 33484 U. S. A. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 XYes 2 No If Yes, Give 42 - 46 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: Specify: Completed by 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental F Important: If item 27 is marked of any Injury or other traumatic ever once. Dorothy Pohinovita ဥ

Physician /Medical

Examiner

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

Herman Gollin				orothy	Rabino	WILL		
19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailing Add	lress (Street and Num	nber or Rural R	oute Number,	City or Town, Sta	te, Zip Code)	33484
Peter Goffin - Son	1	6211 Vi	a Venetia	North,	Delray	Beach,	Florid	a
20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 ☑ Accepted at □ Donation 5 □ Other (Specify)	emoval from State	ace of Disposition emetery, crematory	or other place)	Date 11/16/2	-	oc. Location - Cit		
21. Signature of Funeral Service License		22. Nam Danz	ansky-Gold	iberg M	emorial	Chape1	s, Inc.	
23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	eations that caused the death						Approx Interval	imate I Between
Immediate Cause (Final disease or condition resulting in death)	Advanced	ence of):	malnu	trition dama	n en tia		Onset	and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequ	enoe or):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome pf pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 □Ector	oic pregnancy r (specify)			23d. Date of Month		Year
Part II. Other significant conditions cont Depression, hyp	*					cco use contribu	ite to the cause	of death?
Benign Prosta	te Hypertruph	7			24a. Was an autopsy perform 1☐ Yes 2	prior deat	re autopsy findi er to completion th? Yes 2 \(\) No	of cause of
25. Was case referred to medical examiner?			26. Pla	ce of Death (C	heck only one,			
1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3	DOA Other:	Nursing Home	5 🗆 Residen	ce 6 Other ((Specify)	
27. Mann of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 [Describe how	injury occurred		
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At hor building, etc. (Specify	ne, farm, street, fa	ctory, office	28f.	Location (Stre City or Town,	et and Number o State)	or Rural Route i	Number,
29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examin	ician: To the best of my know er: On the basis of examinat and manner stated.	vledge, death occu ion and/or investig	rred at the time, date ation, in my opinion, d	and place, and leath occurred	due to the cau at the time, da	ise(s) and manne e and place, and	er as stated. I due to the cau	ise(s)
29b. Signature and title of certifier			29c. License number	r	290	d. Date signed (M	Month, Day, Yea	ar)
> Memos	ann		0619	34		11-14-	08	

DHMH 17 Rev 1/2001

State

Registrar

Hebrew

Home Rochville, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mD

Zeba S. Geloo.

1 8 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Hubbard, Jr. Orland James 13 2008 Nov /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Easton Year If Under 24 Hrs. Genesis HealthCare -The Pines Talbot 8. Date of Birth (Month, Day, Year) 10-26-1925 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Maryland Yrs. 83 215-20-2521 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 1 ☐ Yes 2 No Director Caroline Preston 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number pe a within 72 hours after death with USA 21655 "natural", or items 23a 4427 harmony Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Hubbard Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Acme Stores permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other th any injury or other traumatic event, the Warehouse Worker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leolia Wrightson Hubbard, Sr. James Orland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 114 Third Haven Hghts, Easton, Md. 21601 Robert Hubbard/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Federal Hill Cem 11-19-08 Federalsburg, Md. 5 Other (Specify) 21. Signature of Fundral Service License 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover Street, Easton, Md. 21601 23a. Part1. Enter the disease, or complical as the treatment of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine g physician and as the burial-transit Due to (or as a consequence of P.O. Box 68760, Physician/Medical e attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an hash autopsy death? 1 ☐ Yes 2 ☐ No perform 1□ Yes 2 No To the Hospital or Attending Prystciau. within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 25 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 | Inpatient Medical Certification: To 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State

29b. Signature and title of certifier

30. Name and address of person who completes cause of death (Item 23a) (Type, Print)

610

32. Registrar's Signature

DUTCHMAN'S LANE

29d. Date signed (Month, Day, Year)

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, 114 Modical Examinar must be notified at

and Mental Hygiene.

Department of Health ar Important: If item 27 Is any Injury or other trau once.

Physician ' /Medical

Examiner

attending physician for use as the buria

ed by the a

page 2 should be

signed by

has

certificate

within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, I

1 and 2 should be 1 Health and Mental

Pages '

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year 18.00 M November 2000 RUSSELL H. HOWELL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TALBOT HOSPITAL FASTON MEMORIAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
OCT 7, 192 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Days 1**X** M 2□ F Yrs. 1924 MARYLAND 84 213-24-4957 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ∐Yes 2 🙀 No PRESTON MD CAROLINE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 5026 BETHLEHEM ROAD 21655 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER **FARMING** 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HERBERT HOWELL MARY COLLISON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS SEIGLER/SISTER 5026 BETHLEHEM ROAD, PRESTON, MD 21655 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) SPRING HILL CEMETERY 11/21/2008 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 JOHN Z. MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Due to (or as a consequence of) HOURS PULMONARY EMBOLISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 DOA 1 | Yes 2 | Mo 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Records, P.O. Box 68760, **Division of Vital** Hospital or Attending Physician:

HOWELL, RUSSE

725

State Registrar RAMESH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 66441

STREET

2008

November

21601

4b. City, Town, or Location of Death

Hunter-O'Donnell

or Print in Black indelible link. Ensure F	All Copies Are Legiple.	0001
e of Maryland / Department of Health and	Mental Hygiene	3851
Certificate of Death	Reg. No.	

2. Date of Death

November

2008

4c. County of Death

3. Time of Death

 P^{M}

4:00

Physician
/Medical
Examiner

For State Registrar

Annette

. Decedent's Name (First, Middle, Last)

Harriett

4a. Facility Name (If not institution, give street and number)

Shady Grove Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 8-26-1942 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🛣 F 66 Washington, DC 579-58-3242 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shor MD Montgomery Germantown 1 ☐ Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20874 United States 18030 Chalet Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐Yes 2 X No If Yes, Give Year or Dates: Specify ò Q 3 X Widowed 4 ☐ Divorced Completed Department of Heatth and Mental Hyglene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, Ite Madical once." 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dep't of Commerce Human Resources 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vivian Gordon ٩ Richard Hunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6012 Willow Hill Lane Derwood, MD 20855 Amy Hart-Nevins (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Fort Lincoln Crematory 11/18/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funer ! Se vice Licensee 3401 Bladensburg Road Brentwood, MD 20722 1 uhul Lnon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Brain disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed estrictive attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 \subseteq Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛂 No Month Day Year 5 Other (specify) signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 🖾 No 1 ☐Yes 2 ☐No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16220 Frederick Rd #213 Joseph A Ball, MD Gaithersburg, MD 20877 32. Registrar's Signa 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV 1 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11-12 Day 2008 ear Month Hamilton **Physician** 6:00 AM Fayla Jean /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Branch Drive Maribord Spring UPPEY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Sex 5. Social Security Number Funeral Months Days 1 □ M 2 F 549-58-8237 06-23-1946 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked othar than "natural", or Itams 23a or 28a-1 show 10d. Inside City Limits 10c. City, Town or Location 10a, State the Medical Examiner must be notified at Yes 2 □ No Prince George's upper mariboro Completed by Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 20172 Branch Drive USA 14124 3pring 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Private Elementary/Secondary (0-12) College (1-4or 5+) Dietician 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RIVEYS weaver Harold traumatic r 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5935 East Boniwood Turn Clinton, MD 20735 permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any Injury or other trau 313ter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State wasnington, DC 11/21/2008 Glenwood Cemetery ¹ 4
☐Donation 5
☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Upshur St NW Wash, DC 20011 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Metasta Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physiclan/Medlcal the as 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea: 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy 2 Fetal death Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 200 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attanding Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Box 68760. Division of Vital Records, P.O.

Baltimore, Maryland 21215-0036

To the within 2

State

Registrar

Karen Smith

29c. License number MD 359 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Irving St NW Wash, DC 20010 Karen Smith, mo

31. Date filed (Month, Day, Year)

NOV 2 0 2008

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** HOWARD REDERICK NOVEMBER 2018 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** PRINCE 9. Birthplace (State or Foreign Country) HOSPITAL NOTON MARYLAND SOUTHERN If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min 1**√** M 2□ F Months Days Hours 70 CT. 042-30-3084 6-27-1938 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10a. State 10c. City. Town or Location or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-4 shov any injury or other traumatic event, It is Medical Examires must be notified at MD. 1 ☐ Yes 2 🙀 No Director Brandywine 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20613 8504 Heatherwick DR. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X∑Yes 2□No 1957 – If Yes, Give 1961 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Govt. Scale Operator 4 17. Father's Name (First, Middle, Last)
Marsall Howard 18. Mother's Name (First, Middle, Maiden Surname) Be (Lillie Jenkins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 8504 Heatherwick DR. Brandywine MD. Deborah W. Howard (Wife) 20c. Location - City or Town, State Cheltenham MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11-26-2008 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD. Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hunt Funeral 21. Signature of Funeral Service Licenses Home 908 Kennedy St. N.W. Wash. D.C.20011 trances 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CANCER UNG /Medical Due to (or as a consequence of): Examiner URS TO THRIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed SEPSIS Due to (or as a consequence of): physician P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Ye ar 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached to 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 No 1 ☐ Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Natient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 e of death (Item 23a) (Type, Print) Name and address of person who completed call HOSPITAL CLINTON MD 20725 SOUTHERN MD ABASS/ 31. Date filed (Month, Day, Year) NOV 2 0 2008

DHMH 17 Rev 1/2001

Registrar

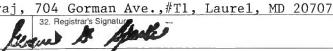
	-	For State Registrar	State of M	arylan		artment of F rtificate of I	lealth and M Death		giene2 Reg. No.	008	38518
٥		Decedent's Name (First, Middle)	e, Last)					2. Date of Dea			3. Time of Death
Physicia /Medic		Ruth Cecile Hir						Month Nov. 1			7:10 A ^M
Examin		4a. Facility Name (If not institution	, give street and number)		4b. City, Town, or	Location of Death		4c. Co	unty of Death	
		Shanti Home				Laure1			Pri	nce Ge	orge's
Funeral		5. Social Security Number		ge (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th v. Year)	9. Birth	place (State or Foreign ntry)
Director		578-12-1270	1 □ M 2 🖾 F	88	Yrs.	Wichitis Days	Tiodis Will.	June 2			ington, DC
70		Usual Residence of Decedent									
ylan		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
Mar Fed S	호	Maryland Princ	e George's	Hyat	ttsvil.	le					1X Yes 2 □ No
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3a o		2403 57th Avenu	ıe			20785			USA		
ns 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto			Race - Amer	can Indian,
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rs af	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2⊠ No	Specify:		Sp	ecify: W	hite
hou	ed	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation		16b. Kind (of Business/Ir	ndustry
in 72	ple	(Specify only highes	st grade completed)	F.)	(Give life. I	kind of work done on DO NOT use retired	during most of work	ing			
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filed Hyg other		17. Father's Name (First, Middle,	Last)				18. Mother's Name	e (First, Middle,	Maiden Sur	rname)	
d be ental ced c	o Be	Thomas Karr					Flora Ir	ene Kre	iner		
hould nd M mari	ဥ	19a. Informant's Name/Relations	hip (Type Print)		19b. Mailir	ng Address (Street	and Number or Rur			wn. State. Zi	p Code)
d2s thar trau trau		Joyce M. Woodwo		ter			nue, Hyat				,
1 an Heal em 2 ther		20a. Method of Disposition	Jen / Baugn					Date		ion - City or T	own, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylgiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Modical Evantine, must be notified at once.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		For	emetery, crer t Linc	sition (Name of matory or other place oln Cemet	tery 11/2	2/2008			Maryland
permit. Depart Import any Inj once.		21. Signature of Funeral Service	Licensee	7-1-		2. Name and Addre		e. P.A.			more Avenue e, MD 20781
Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that cause only one cause on each	ine.	n. Do not ent	er the mode of dyir					Approximate Interval Between Onset and Death Years
/Medical Examiner		resulting in death)	Due to (or a								
	er	Sequentially list conditions,	b. Due to (or a	a conseni	ience of):						
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ath certifi ttending p or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant		Ideath 3	☐ Ectopic pregnanc	ey .		23d	. Date of deli	very Day Year
de a	10			at time of d	leath 5 L	Other (specify) _					
at the de by the a tached fo	hys	9 ☐ Unknown	9 □ Unknown								
is that the deigned by the a		9 ☐ Unknown Part II. Other significant condition	9 □ Unknown				ren in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
quires that the de en signed by the a uld be detached fr	þ		9 □ Unknown				ven in Part I.				the cause of death?
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To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending placemental Director. After this certificate has been signed by the attending placement of the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	To Be Completed by	Part II. Other significant condition Dementia 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investign investign investign determined by the pending investign investi	Hospital: Hospital: 1 Inpa gation 28a. Date of In (Month, E building, 6 ng Physician: To the bess and manner sand manner sa	ient 2 jury ay, Year)	ER/Outpatier 28b. Time o	nderlying cause given to a DOA Other of 28c. Injunyor of the ceet, factory, office the occurred at the time.	26. Place of Deat ier: 4 Nursing Ho ry at k? lYes 2 No	24a. Was auto performent of the performance of the pe	an psy 2 No 2 N	24b. Were aut prior to c death? 1 Yes 3 Other (Specicurred	opsy findings available ompletion of cause of 2 □ No Assisted lifty) Living ral Route Number, stated. to the cause(s)

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Rajkumar G. Bhojraj, NOV 2 0 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Evans Joseph Herl	1	t State	of Maryland / Depa Ce	artme	ent of Healt ate of Deatl	h and	d Mental	Hygi	ene Reg.	2	0 0 8	3851
Physician Medical Examine	1	eqistrar Decedent's Name (First, Middle,Las	oseph		HERBER	т			Date of Death Month D Ovember 1			. Time of Death 1210 hrs
Medical Examine		EVANS J 4a. Facility Name (if not institution, giv Prince Georges Hospital C	e street and number)			own, or	Location of De		ovember	4c. County of		6 X
Funeral Director	1	5. Social Security Number 6. Social Security Number 1 X	7. Age (In yrs. 7 2	last birt	hday) If Unde Month:	r 1 Year Days			Date of Birth(9. Birthp Foreign - Coun	place (State or PENNSYLVAN Try
yland -f show any once.	Ī	Usual Residence of Decedent	GEORGE S 10c. City		or Location WASHING				100	. Citizen of Wh		Od. Inside City Limits 1 X Yes 2 No
tith the Maryland 23a or 28a-f show notified at once.		3006 RAMSGATE F			2	2074				USA		
or items		11. Marital Status 1 Never Married 2 Marriec 3 Widowed 4 Divorcec		AVY	1 Yes 2	y Cubar X No	, Mexican, Pue	erto Ric	an, etc.).	White Specify:	e, etc.	n Indian, Black, BLACK
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygies and the filed within and the filed within an intural?, or other traumatic event, the Medical Examiner To Bo Completed by	neieluo	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	-	Decedent's Usual during most of wor LATE PRIM	king life				GOVERN		
ore, MD 21215-0036 tes 1 and 2 should be filed within 721 of Health and Mental Hygener (If item 27 is marked other than ", The Po Commoder	a l	17. Father's Name (First, Middle, Last NATHANIEL HERBER	RT SR.				EDNA	JAC	OBS	iden Surname		
MD 21 d 2 should d 2 should lth and Me n 27 is mar numatic ev		19a. Informant's Name/Relationship (JEFFREY HERBE	RT/SON		b. Mailing Address	GAT	E PLACE	E FO	RT WAS	HINGTON	N,MD	20744
Baltimore, permit. Pages 1 am Department of Heal Important: If iten injury or other tra		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specify	Removal from State	cremat	of Disposition (Nar tory or other place VIEW CEN	1				20c. Location Florence	S	own, State outh arolina
Balti permit. Departr Import injury	- 1	21. Signature of Fune (15)			22. Name and					INS FUR		
Physician - /Medical xaminer		failure. List only one cause on e	pilotions that caused the deat ach line. Multiple Injuries Due to (or as a consequence Due to (or as a consequence	of):	ot enter the mode	of dying,	such as cardi	ac or re	spiratory arres	t, snock, or he	ап	Approximate Interval Between Onset and Death
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Box 68760, a death certificate be the attending physic ed for use as the burning in the second control of the c	sician/i	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of pre 1 Live birth 4 Pregnant at time of o		Petal death Other (Spe	3 cify)	Ectopic pre	egnancy		23d. Date o Month	Da Da	ay Y ear
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of Vital Rec	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	/ ER/C	Outpatient 3	26.Plac DOA	Other N			tesidence 6	Other:	
- = - \ 4 1	- 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28e Place of Injury - At	FOI 111	UND: 5 hrs	1	yes 2 V No	Dr	iver in auto	ow injury occur o/auto collis reet and Numb	sion	al Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		3 Suicide 6 Could no determine 29a. Certifier (Check only 1 Certifying Physical Certif	(Specify) Major Ro	ad / H	lighway eath occurred at th	e time, c	ate and place,	and du	e to the cause	(s) and manne	r as state	d.
To the J within 2 To the J complet	Medical	one) 2 Medical Examine 296. Signature and title of certifier	er:On the basis of examination and manner stated.	and/or	investigation, in m	y opinio	n, death occur se number	red at th	e time, date a	nd place, and 29d. Date sign	due to the	cause(s)
) Caloler	<u>u</u> ()	m 225		O.C	M.E.			November	16, 20	08
CR 15			stant Medical Examiner	r 11	1 Penn Stree	t, Balti	more, MD	21201				
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	TUE .	The same of the sa							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 11:20 Quang Huynh 13 2008 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
May 17, 1942 6. Sex **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min. 1 X M 2 □ F Director 66 Vietnam 579-17-0846 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a 2904 Chapel View Drive 20904 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Specify. Asian Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 Is marked other than other traumatic event, Inc. We Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Housekeeping Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Tuc Van Huynh Hai Thi Dang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lien Nguyen - Spouse 2904 Chapel View Drive, Silver Spring, Maryland 20904 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 11/22/2008 Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer Years /Medical Due to (or as a consequence of): Examiner Pleural Effusions Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pt d for use as tf 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Yes 2 No 3 Probably 4 Unknown COPD, Cachexia, Sacral Pressure, Ulcer Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2. No 2 XNo 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation nours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065485 iD Daruch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Suparrich, M.D., RSM, 1500 Forest Glen Road, Silver Spring, Maryland 20910

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV

18

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year 2008 Physician $8:35 a^{M}$ November 17, Nazha R. Huff /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2**X** F 578-22-6951 July 25, 1925 83 Washington, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f show the Medical Econdition at 1 ☐ Yes 2 🕱 No Prince George's Laurel Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20707 USA 14425 Bonnett Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ∐Yes 2 √2 No Specify. Specify: White þ ¥ Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fill f Health and Mental H Item 27 is marked oth other traumatic even Olga Nader Elias Rattal ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14425 Bonnett Lane, Laurel, MD 20707 Nicholas E. Rattal/Nephew permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Nov. 20 1 Burial 2 ☐ Cremation 3 🖾 Removal from State Shenandoah Memorial 4 ☐ Donation 5 ☐ Other (Specify) 2008 Winchester, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or comil-licitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or as a consequence of) Examiner law requires that the death certificate be executed Due to (or as a consequence of) burial-Box 68760. physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2 🗷 No P.O. 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 Diabetes Mellitus, Hypertension 1 Tes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed Hospital or Attending Physician: The certificate 2 🗆 No 2**X** No 1 □Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2√∑ No ¹x Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 200 D32332 November 17, 2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Gupta, MD 9801 Georgia Avenue, #220, Silver Spring, MD 20902 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 18 NOV Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ror State RegistraryMFND#18,20bperINF,11/26/08,FMV,MccCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dav Year Donald Edward High М November 15 2008 /Medical 2057 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01nev Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Days Hours 1⊠M 2□ Months Min Director 236-34-0687 November 28,1927 West Virginia Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Eventine is until to an once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18213 Bowie Mill Road Funeral 20832 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Navy 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify þ 3 ☑ Widowed 4 ☐ Divorced Specify: Year or Dates WWII White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Classification Specialist U.S. Customs Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Freda Ethel Bias hal Rice ျှ James Edward High 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. High - Son 18213 Bowie Mill Road, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 11-29-2008 4 ☐ Donation 5 ☐ Other (Specify) Spring Hill Cemetery 11/28/2008 Huntington, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility T. Walred Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver

23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gastrointestinal Hemorrhage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
We the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) □Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Coronary Artery Disease 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Congestive Heart Failure autopsy performe 1 □Yes 2 No Coagulopathy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mail Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifie 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Heather Lorenzo, M.D., 18101 Prince Philip Drive, Olney, Maryland 20832 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 18 Registrar VON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

and manner stated

Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Of Maryla Registrar	•	artment of He rtificate of D		, ,	giene Reg. No. 🥠 🕦	00 0050
	Physici	an	Decedent's Name (First, Middle, Last) Frances Dorothy Harrup				2. Date of Dea Month	th Day Ye	3. Time of Death
1	/Medic	al	4a. Facility Name (If not institution, give street and number)		4b, City, Town, or I	ogation of Deeth	Novembe	r 14, 2008	8:20 a M
	Examin	er						4c. County of D	
	Funeral Director		2709 Woodedge Road 5. Social Security Number 6. Sex 7. Age (In yr. 1 or 1	s. last birthday) Yrs.	Silver Spr If Under 1 Year Months Days		8. Date of Birth (Month Day ept • 9,	Montgome 1923 Mj	ery Birthplace (State or Foreign Country) Innesota
	pu 🛦		Usual Residence of Decedent 10a. State 10b. County 10c. 0	City, Town or Lo	agtion				40d Incide Other Linia
	Aaryla f sho	ıo							10d. Inside City Limits 1 ☐ Yes 2 🛣
	the N	Director	Maryland Montgomery 10e. Street and Number	Silver	Spring 10f. Zip Code			10g. Citizen of What	
	th with		2709 Woodedge Road		20906			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Marical Event mint be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Was Decedent of His f Yes, specify Cuban I □Yes 2X No	panic Origin? (Spec , Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	14. Race - A Black, W Specify: V	
21215-0036	in 72 hour "natural Isdical Ex	Completed t	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done du DO NOT use retired)	tion uring most of working	g	16b. Kind of Busine	
212	d withi	mo	Elementary/Secondary (0-12) College (1-4or 5+)		okkeeper			Accounting	
Maryland	uld be filed Aental Hy, rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Bert MacDonald			18. Mother's Name ((First, Middle,		
, Mary	and 2 shorestith and 1 strains in 27 is master trauma		19a. Informant's Name/Relationship (Type. Print) Anne Foglesong/Daughter	19b. Mailin 2709 Woo	ng Address (Street al Medge Road,	nd Number or Rural Silver Spr	Route Numbe ing, MD 2	r, City or Town, Stat 20906	e, Zip Code)
Baltimore,	Pages 1 and the nent of He not. If item iry or oth				sition (Name of natory or other place wen Cemeter			20c. Location - City	
Balti	permit. Departr Importa any injt		21. Signature of Funeral Service Licensee		Name and Address	of Facility Ollins Fune		Inc.	ng,Maryland
	Physician	1 10	23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ath. Do not enti	er the mode of dying	, such as cardiac or	respiratory an	Spring, MD 2 rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a. Coronary Arter Due to (or as a conse	equence of):	NG.				Many Years
	ted sit	niner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury)	equence of):					
50,	tificate be executed g physician and as the burial-transit	Il Examiner	that initiated events resulting in death) Last cHyperlipidemic Due to (or as a conse						
68760,	tificate ig physi as the t	edical	d						
. Box	death cer e attendin d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown 23c. If yes, outcome of pregressions and the pregnant at time of the pregnant at time	tal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
rds, P.	es t igne be c	δ S	Part II. Other significant conditions contributing to death but not re	esulting in the ur	iderlying cause giver	in Part I.	23e. Did to		e to the cause of death? Probably 4 Unknown
Records,	law rec nas bee	Completed					24a. Was a		autopsy findings available to completion of cause of
		a l	25. Was case referred to medical			26. Place of Death (perform 1 □ Yes	med? death 2 Ix No 1 □ Y	es 2 □No
	Physici this ce	2 B	examiner? 1 ☐ Yes 2 🗷 No Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatien	Other			ence 6 Other (S	pecify)
ם פ	ding Pt h. After th funeral	ü	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)	28b. Time of Injury	28c. Injury Work?	at 28		ow injury occurred	
Division of	or Attending Physician: after death. Director: After this certific I in by the funeral director,	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At i	home farm stre		es 2 No	of Location (S	tract and Number or	Purel Pouts Number
≥ .	al or / s after I Dire d in b	ert	4 Homicide determined building, etc. (Spec	cify)	ot, lactory, office	20	City or Town	n, State)	Rural Route Number,
:	Hosp 4 hou Funer tely fil	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examiner and manner stated.	nowledge, death	occurred at the time restigation, in my opl	e, date and place, ar nion, death occurred	nd due to the o	ause(s) and manner ate and place, and c	r as stated. due to the cause(s)
:	Fo the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License		2	9d. Date signed (Mo	
	10		, -		D43	496		November	14, 2008
	, ,		30. Name and address of person who completed cause of death (Ite Mohammad Khalid, MD 12001 Ferra		Print) , Wheaton, I	MD 20906			
	Stat Registra	•	31. Date filed (Month, Day, Year) 32 Tegfstrar's Sign						

State State Registrar AMEND#23a(a-d)perMD11/19/08, BM, Mc Sertificate of Death

1. Decedent's Name (First, Middle, Last)

DAVID, H

4a. Facility Name (If not institution, give street and number)

2104 Randolph Road, #108

Physician

/Medical

Examiner

4b. City. Town, or Location of Death

Silver Spring

Reg. No.

14

2008

U.S.A.

14. Bace - American Indian

Gun Repair

Montgomery

Massachusetts

White

9. Birthplace (State or Foreign

10d Inside City Limits

1 ☐Yes 2 X No

4c. County of Death

1:29 a M

2. Date of Death Month

November

Box 68760. P.O. Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit After this certificate has been signed by funeral director, page 2 should be detact

11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Atrial Fibrilation 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ₹ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 2 🖸 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐Yes 2 ☐No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD D063672 November 14, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali Ghorbani, M.D., 7610 Carroll Avenue, #480, Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year) Registrar's Signature State 1 8 2008 Registrar NOV **ORIGINAL**

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 15, 2008 Month **Physician** Wallace Jones November 22:04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 1, Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 1**★** M 2□ F Months Days Hours 577-42-3856 76 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 No Director Marvland Prince George's Oxon Hill 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 20745 5619 Helmont Drive United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Armed 2 No 11. Marital Status Black. White, etc. 1 □ Never Married 2 □ Married Black 1 □Yes 2 XNo Yes. Give Specify: ģ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Windows Designer Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Jones Mildred Baylor ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sheila R. Jones - Daughter 5619 Helmont Drive Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park: Nov 21, 2008 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Si nature of Funeral Service Livern 4001 Benning Road, NE Washington, DC 20019 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

/Medical Examiner law requires that the death certificate be executed and burial-tran P.O. Box 68760. attending physician the as ρı ed by the detached Division of Vital Records, cate has been si , page 2 should b After this

Funeral

Director

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items 23a

'natural", or

श Hygiene. I other than "

is marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event

Physician

within 72 hours after death

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examinar must be notified at

Prospital or Attending P 24 hours after death. Funeral Director: After t completely filled in by the 24 hours a To the I within 2

State NOV 1 8 2008 Registrar

(Check only one)

Name and

29b. Signature and title of certifier

SOY Date filed (Month, Day,



son who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11-14-2008 **Physician** 3:45PM Jackson William J /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospitol Ctr Clinton Prince George's Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 2-20-1949 **Funeral** Days Hours Months 1 **⅓**M 2 □ F 579/64/8321 59 Washington DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be multied at 1X Yes 2 □ No Director Md Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10704 Draco Pl 20735 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No ģ Specify: Black 3 ☐ Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Ing. Monce. Import/Export Commerce Department 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William L Jackson Miriam V Miller ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10704 Draco Pl Clinton Md 20735 Miriam V Jackson, Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/21/200B 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Riverdale Crematory 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, Md 22. Name and Address of Facility Taylors Funeral Home 21. Signature of Funeral Service Lix 1722 North Capitol St NW Washington DC 23a. Part 1. Enter the disease, or compfications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Immuno DEFICIENCY SYNDROME QUIRED Saque itlany list our dilicite, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) this certificate has been signed by the al director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NEMIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

I Director: Ald in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

Division of Vital Records, P.O. Box 68760. within 24 hours aft

To the Funeral Di

completely filled in

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Surraits Rel, Clinton-MD20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		1 - State Registrar	of Maryland / De	epartment of Certificate			Reg. No.2008	3852
Physic /Medi Examii	cal	Decedent's Name (First, Middle, Last) Joseph Clift Jackso Aa. Facility Name (If not institution, give street and		4b. City, Tov	vn, or Location of Deatl	2. Date of Dea Month Nov.	12 2008 4c. County of Deat	3. Time of Death 1630 M
Funeral Director		Calvert Memorial Hosp 5. Social Security Number 395-10-9383 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Y	e Frederick (ear If Under 24 Hrs. ays Hours Min.		Calvert	nplace (State or Foreign untry) DW3
e Maryland la-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George	s loc. City, Town of Bowie	or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
d within 72 hours after death with the Maryland jiene. In than "natural", or itams 23a or 28a-1 show than Medical Evandrational than notified at	Funeral Director	Armed	ecedent Ever in U.S. Forces?		de 0715 of Hispanic Origin? (S Cuban, Mexican, Puert		10g. Citizen of What Co USA 14. Race - Ame Black, White	rican Indian,
72 hours afte "natural", or i dical Exami	Completed by Fo	If Yes,	Dates: 1946	1 ☐ Yes 2 ☑ ecedent's Usual O Give kind of work of	ccupation	rking	Specify: W	hite
office of the vent,	Be Compi	17. Father's Name (First, Middle, Last)	(1-4or 5+)	te DO NOTuse n 11 Estate	Salesman 18. Mother's Nar		Real Esta	te
and Men is marke	70	Charles C. Jackson 19a. Informant's Name/Relationship (Type, Print) Thomas Jackson — Son					er, City or Town, State, 2	lip Code)
permit. Pages 1 and 2 Department of Health important: If item 27 any injury or other tra ance.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		22. Name and A	ematory 11	rt Linco	20c. Location - City or Brentwood, In Funeral	MD
cale be executed by Scienary (Medical Examiner physicien and physicien a	dical Examiner	Sa quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	SEPSI to (or as a consequence of)	5 owel	Obstruct		rest,	Approximate Interval Between Onset and Death
that the death certification by the attending phy detached for use as the	Physician/Med	in the past 12 months?	outcome of pregnancy e birth 2 Petal death egnant at time of death known	3 □Ectopic pregn 5 □ Other (specif			23d. Date of deli Month	very Day Year
The law requires that the ste has been signed by the pege 2 should be detached.	þ	Part II. Other significent conditions contributing to	death but not resulting in the		e given in Part I.		obacco use contribute to 'es 2 □ No 3 □ Pro	
icisn: The law r certificate has be ector, pege 2 sh	e Completed	Acute Renal Respiratory Fo 25. Was case referred to medical	Failure	2		1 ☐ Yes	sy prior to death? 2 No 1 □ Yes	topsy findings available completion of cause of 2 No
ding Phys h. After this tuneral dir	Certification: To B	examiner? 1 Yes 2 No Hospital: 1 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	Inpatient 2 ER/Outpute of Injury onth, Day Year) ce of Injury - At home, farm Iding, etc. (Specify)	ne of 28c.	Other: 4 Nursing H Injury at Work? 1 Yes 2 No	28d. Describe h	lence 6 Other (Special Control of the Control of th	
To the Hospitei or Atten within 24 hours efter deatl To the Funeral Director: completely filled in by the	Medical Cer	29a Certifier 1. Certifying Physician: To (Check only 2 Medical Examiner: On the	he had of my knowledge :	fasith occurred at the investigation, in i	he fille date and place my opinion, death occu	rangelines to these	squeste) en totannar se	etat5d. to the cause(s)
To the To the Comple	Mec	29b. Signature and title of certifier	anner stated.	29c. Li	cense number 50653		29d. Date signed (Month	n, Day, Year)
+1		30. Name and address of person who completed c	tuse of death (Item 23a) (Ty	(pe, Print) Gy	AN C	Sura	NA	20751

DHMH 17 Rev 1/2001

sician and burial-transit the attending physician as the use detached for cate has been signed by page 2 should be detacl -To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Completed

Medical Certification: To

25 Be

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐ Yes 2 HNo 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 9☐Unknown

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

autopsy performe 2 No

Avenue Laurel Moryland 20707

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 【No

Day

Year

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 XNo

Pennsylvania

Black

9:00A M

Year

2008

Black, White, etc.

Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 Nursing He	ome 5 🗖 Residence	6 □Other			
Manner of Death	28a. Date of Injury	28b. Time of	28c. [njury at	28d. Describe how inju	ry occurred			

27 1 X Natural 2 Accident 3 ☐ Suicide 4 ☐ Homicide

Hypercholasterol

5 ☐ Pending investigation 6 ☐ Could not be

1 ☐ Yes 2 ☐ No M Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Physician

D61067

November 11,2008

6 ☐Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13932 Baltimore LAURA KHANDAGLE

31. Date filed (Month, Day, Year) State 1 8 2008 NOV Registrar

. Registrar's Signature

24

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year) NOV 2 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

200 LARGO MD 207

11/19/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month Day November 16, 2008 Kuster Mae 4c. County of Death

1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 5:35 a M Charlotte /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea Sept. 16, 5. Social Security Number 6. Sex **Funeral** Year) 1 □ M 2 1 F Months Days Hours Sept. 77 Maryland 579-40-1976 1931 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 K No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2921 N. Leisure World Blvd., 20906 #323 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify.White ģ 3 Widowed 4 □ Divorced ed other than "natural"; event, the Medical Ext Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 7 Is marked of traumatic ever Pages 1 and 2 should be Unknown Annie Unknown ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health in item 27 la Diane Parker/Daughter 15004 Bushy Park Road, Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₽ Nov. 20 = 5 1 🖾 Burial 2 □ Cremation 3 □ Removal from State Department of Important; If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) 2008 Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Lung Carcinoma Sequentially list conditions, if any adding to in reciat, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transli resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2★ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. this certificate has been signed by the al director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 □ Yes 2 □ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 🗓 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending death. investigation 1 □Yes 2 □ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

of Vital Records, Division or Attending filled in by the f To the Hospital within 24 hours a To the Funeral C Hospital

D

Amuel 31. Date filed (Month, Day, State NOV Registrar

29a. Certifier

(Check only

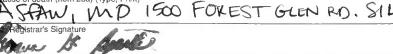
29b. Signature and title of certif

30. Name and address of person

cal

2008

who completed



ause of death (Item 23a) (Type, Print)

18

1 🗷 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D00506

29d. Date signed (Month, Day, Year)

16

2011

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Madhavi Hubbly, MD

Machan Hubby

18

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

9901 Medical Center Drive, Rockville, MD 20850

29c. License number

20062562

29d. Date signed (Month, Day, Year)

NOVEMBER 16, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38532 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Ronald Stanislaus Karwoski November 12, 2008 2:51 p /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 13, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 166-30-5274 Months Days Hours Min. Pennsylvania 17 M 2 □ F 69 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at some. 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TX No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9519 Seminole Street 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1⊊Yes 2 ☐ No IfYes, Give Year or Dates: 1956–60 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 21 Married Baltimore, Maryland 21215-0036 1 ☐Yes AND Specify. Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Programmer Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander V. Karwoski Frances Smyczek ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Karwoski/Wife 9519 Seminole Street, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 18, Gate of Heaven Cemetery 4□Donation 5點Other (Specify) entombment Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. re of Funeral Service License 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Thinision of Vital Records, P.O. Box 68760 Physician/Medical ettending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 □Yes 2 □No the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 st 24a. Was an autopsy 1 □ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 TNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Daniel K. Sherk, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) Registrar's Signature State 18 NOV

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 38533 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Month **Physician** 14 2008 9:15 Cary J. Landry Nov. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6500 Freetown Road Rm 325 Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 🔀 M 2 🗆 F Director 73 004 32 5319 03-05-1935 Maine Usual Residence of Decedent death with the Maryland 10c City Town or Location 10a. State 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ZNo Director Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 6500 Freetown Road Rm 325 21044 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1953-61 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>ک</u> Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Claims Adjuster Insurance permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dora Desjardins Charles Landry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Landry-Fida/Daughter 7936 Brightmeadow Court Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-18-2008 Ellicott City, MD St. Johns Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses M01044 60 4112 Old Columbia Pike Ellicott City, MD 21043 23a, Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alcoholic Liver Cirrhosis Physician 5 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alcohol Abuse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient 1 ☐ Yes 2 ☑ No ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. D56531 Nov. 17, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, MD 8600 Snowden River Parkway #301 Columbia, MD 21045 31. Date filed (Month, Day, Year) 32. Registrar's Signature State is augus NOV 1 8 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38534 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Barbara Long 7008 2:05AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Year If Under 24 Hrs. Coastal Hospice Lake Wicomico 94 8. Date of Birth (Month, Day, Year) 12/21/1949 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 1 □ M 2 🗙 F 58 217-54-5480 Director Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Experiment aust be notified at 1 No 2 No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 1031 Riverside Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after lealth and Mental Hygiene. 1 ∐Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ Specify: 3 Nidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lorenz W. Dennis Regina Ziegler မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1031 Riverside Dr., Salisbury, MD 21801 Angela McLaughlin/daughter permit. Pages 1 and Department of Healt important: if item 2: any injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/19/08 Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 nature of Funeral Service Licensee Choramon CFSP 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentiasy list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmorare 28 frueliere 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 🔀 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 🛚 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2084 11-15-2008 D 29505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Barbara

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar Cel	rtificate of Death	Reg. No. 2	8 38535			
	1. Decedent's Name (First, Middle, Last) Physician AR THA			2. Date of D Month NOVEMO	Day Year	3. Time of Death			
-Ka	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	13			
	Examin	er	The Johns Hopkins Hospital	Baltimore City					
5	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 579-64-2408 Yrs.	Months Days Hours Min. (Month, L	Day, Year) Co	rthplace (State or Foreign ountry) irginia			
	land low		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low	ocation		10d. Inside City Limits			
	a-f sh fied a	ctor	DC Washin	gton, D.C.		MXYes 2 □ No			
re, Maryland 21215-0036	d within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	al Director	10e. Street and Number 444 Necomb Street, S.E.	10f. Zip-Code 20032	10g. Citizen of What Co	ountry?			
	or items ?	Funeral	1 1√2 Never Married 2 □ Married 1 □ Yes 2√2√No	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		te, etc.			
	atural", c	ted by		edent's Usual Occupation a kind of work done during most of working	Specify:	Black			
	I within 72 iene. r than "nai he Medic	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired)	Private	Industry			
	be file tal Hy d oth event,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	lle, Maiden Surname)	-			
	z snould and Mer is mark aumatic	오		Shirley Des Sing Address (Street and Number or Rural Route Num Girard Street, N.W. hington, D.C. 20011	perate nber, City or Town, State,	Zip Code)			
	He He		20a. Method of Disposition 1 Typerial 2 Cremation 3 Removal from State	osition (Name of Date amatory or other place)	20c. Location - City or				
Saltin	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licensee	Mem. Pk. 11-20-200 22. Name and Address of Facility alph Williams Funera	1 Service				
	TD = # 0		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	813 Potomac Ave., SE: ter the mode of dying, such as cardiac or respiratory	Wash., DC	Approximate			
/Med	Physician /Medical	8 1	shock, or heart failure. List only one cause on each line.						
	Examiner	-	Securificity list conditions b. SQUAMOUS CEU	Due to (or as a consequence of): 5. SQUAMOUS CELL LUNG CANCER					
nted ansit		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
, 20	ificate be executed g physician and as the burial-transit		resulting in death) Last Due to (or as a consequence of):						
9/89	ificate g phys as the	Medi	3.						
hat the death cert by the attending detached for use	the attending	Physician/Medical		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of de Month	elivery Day Year			
	ires that the signed by do be detact		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 YUnknown						
Hecords,	rsician: The law requing certificate has been director, page 2 shou	Completed by	SUPRAVENTRICULAR TACHYC	per	ppsy prior to completion of cause of ormed? death?				
VItal	an: Th tificate tor, pa	a	25. Was case referred to medical	1 ☐ Yes 26. Place of Death (Check only		s 2 No			
<u>></u>	Physiclan: this certificated director,	To B	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)						
noi	Attending P er death. ector: After ti by the funers	Certification:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident 28a. Date of Injury (Month, Day Year) 28b. Time (Injury Injury In		e how injury occurred				
DIVISION	2 # F E		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location City or To	(Street and Number or F own, State)	Rural Route Number,			
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.						
	No the congression of the congre	Me	29b. Signature and tiple of certifier / MESICAL DOCTOR	29c. License number	29d. Date signed (Month, Day, Year) November, 11, 2008				
	3		30, Name and address of person who completed cause of death (Item 23a) (Type DAV: D COSGROVE, THE JOHNS HOFKI		olfe St, Baltim	ore, MD, 21287			
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 7 2008 32. Registrar's Signature	,					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAIRS Day Month KEVIN 3.15 **Physician** JEOR GE NOVEMBER 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea May 29 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F Days Wilm. Delaware May **Director** 222-46-5800 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Wilmington DE New Castle 10f. Zip-Code 10g, Citizen of What Country? USA 19805 621 Greenhill Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 [7] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 white 1 ☐ Yes 2 XNo þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Facilities Services Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dixie Thompson Thomas E. Mairs ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) partment of Health a cortant: If item 27 is injury or other trau 16649 Shetland Avenue Greenwell Springs, LA 70739 Patricia Kramer 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Pages 1 Grace rawn membr 1'21 Department o Important: If i any injury or or 1 X Burial 2 Cremation 3 Removal from State Nov 22 2008 New Castle, DE 4 Donation 5 Other (Specify) Park 21. Signature of Funeral Service Licenses 1980322. Name and Address of Facility 211 2506 Concord PIke Wilm DE Chandler Funeral Home 23a, Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MULTIORGAN FAILURE Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical ARDIOGENIC SHOCK Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Box 68760. Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the appage 2 should be detached it 2 No. P.0 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 of Vital Records, 3 Probably 4 Unknown 1 Tyes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 5 Pending investigation 1 🔲 Yes 2 🗌 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide

Division

al or Attending Physis s after death. Il Director: After this o To the Hospital of within 24 hours at To the Funeral D completely filled it

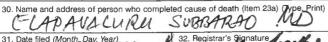
> State Registrar

29a. Certifier

(check only

29b. Signature an

Medical



and manner stated

600 North Wolfe St. Baltimore, MD, 21287

NOVEMBER

29d. Date signed (Month, Day, Year)

2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

08-08354 Wilbur Messick Med

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Otate	or wary		tificate of	Death		·	Re	eg. No.	200	8 3853
Physicia	an/	Decedent's Name			MEC	ciai				Date of Deat Month November		Year	3. Time of Death 1057 hrs
ical Exami	ner	4a. Facility Name (if r		RNER e street and nu		SICH	b. City, Town,	or Location		November		ounty of Death	1007 1113
		21059 Nantic					Bivalve				Wic	DMiCD	
Funeral		5. Social Security Nu	mber 6. Se	ex	7. Age (In yrs. la	ast birthday)	If Under 1 Ye		er 24Hrs.	8. Date of Bir	th(MM/DD/	YYYY) 9. Birti Foreigi	hplace (State or
Director		214-28-16	58 12	M 2 F	45	Yrs		ays Hours	Min.	08-26	-193	Col	intry) Mb
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Maryland 28a-f show any d at once.	Director	10e. Street and Numi	WICOM ber	100	1 101	VALVE	10f. Zip Code			1	0g. Citizen	of What Coun	try?
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (F			MATROCI	ام ام		18.Mothe	,	First, Middle, I	4	_ ′	150
D 21215-00; should be filed with and Mental Hygiene 7 is marked other t	o Be	CORNEL 19a. Informant's Nam	ne/Relationship (1	ype, Print)	14 1F-22	19b. Mailing	Address (Str	reet and Nur					
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. "His filem 27 is marked other than "natural", or items 23a or 28a-f shown: If item 27 is marked other than "natural", or items 23a or 28a-f shown: If other traumatic event, the Medical Examiner must be notified at once.			MESSIC		FE)	2104	MAN PZ	TICOK	TH 3	BIVA	WEI	D Al	ઢાય
ore, ME ss 1 and 2 sl of Health an If item 27 ner traums		20a. Method of Dispo		-	20b.	Place of Dispos crematory or ot	ition (Name of the place)	cemetery,		Date	20c. Loc	ation - City or	Town, State
Pages Pages nent o lant:		4 Donation 5	Other Specify				CEMET			2-3008	BIV	WEY	\mathcal{D}
Baltimore, MD 21 permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ev		21. Signature of Fund	eral Service Licer	see	20110		Name and Address			14500		a Russ	LUE AND MOULE
Physician	Н	23a. Part . Enter the	disease, or comp	lications that c	aused the death		he mode of dyir		4 1 1 2	MF PO respiratory arr		or heart	Approximate Interval
/Medical		failure. List only Immediate Cause (F	one cause on e		ınshot Wour	nd of Chest							Between Onset and Death
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certif certif ending use as	Physician	past 12 months?		1 Live b	oirth nant at time of de	noth	etal death ther (Specify)	3 Ectop	ic pregnar	icy	I	onth [Day Year
Boy e death the att	hysi	1 Yes 2 N		9 Olkin									
P.O. Box 68: ss that the death certifi- gned by the attending or detached for use as	by P	Part II. Dther signifi Melanoma	icant conditions	contributing to	o death but not r	esulting in the	underlying caus	e given in F	art I.				the cause of death?
Vital Records, P.C. hysician: The law requires that this certificate has been signed I director, page 2 should be dete		Wicianidina	<u> </u>						-	24a. Was		24b. Were au	topsy findings available
COr law re has b e 2 shc	ompleted				_						rmed?	death?	completion of cause of
Re n: The fifficate or, pag	ပ	25. Was case referre	ed to medical			_	26.Pl	ace of Death	(Check o	1 Yes	2 No	1 🗸 Ye	es 2 No
Vita ysicia his cer direct	o Be	examiner? 1 ✓ Yes 2		Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DDA	Dther;	Nursing	g Home 5	Residence	e 6 🗸 Other	r: Scene
Division of Vital Records, pital or Attending Physician: The law requir ours after death. eral Director: After this certificate has been si filled in by the funeral director, page 2 should t	-	27. Manner of Death		28a. Date	of Injury Day,Year)	28b. Time of		njury at Wor	_ 9	28d. Describe Subject sho		occurred	
sion ttendi death ctor:	atio	1 Natural 2 Accident	5 Pending Investigat	ion Nov 7, 2	2008	FOUND: 1053 hrs		Yes 2 ₩	No				
Jivis al or A s after al Dire	Certification	3 Suicide	6 Could not determine	be	e of Injury - At h Single Far		et, factory, offic	e building, e		or Town, \$21059 Nantic	State)		ıral Route Number, City
fr e or		4 Homicide 29a. Certifier 1 (Check only	Certifying Physic	(00000)			rred at the time	, date and p					
To the How within 24 h To the Fur completely	Medical	one) 2	Medical Examine	r:On the basis and manners	of examination a	nd/or investiga	ition, in my opin	ion, death o	ccurred at	t the time, date	and place	, and due to th	e cause(s)
F % F 8	Me	29b. Signature and t		~				ense numbe	r			- '	nth, Day, Year)
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ORIGINAL

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Physicia /Medic Examin

Funeral Director

	•	1 - State Registrar		(Cert	ificate of	Death			Reg. No.	2008	3853	3
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dica nine		4a. Facility Name (If not institu Southern Marylar				4b. City, Town, or Clinto		of Death		1	County of Death		
ral or		5. Social Security Number 193–12–4194 Usual Residence of Decedent	6. Sex 7. Age 1	e (In yrs. last birth 87 y	rs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D August	7th Year 19	121 COL	pplace (State or Form intry) sylvania	eig
	Director	Maryland Prince	ce George's	Oxon Hi								10d. Inside City Lin 1 ☐ Yes 2 🔯	
		10e. Street and Number 1512 Colony Road	i			10f. Zip Code 20745	5			10g. Citi	zen of What Cou USA	intry?	
	u by runeral	11. Marital Status 1 □ Never Married 2 □ M 3 XXWidowed 4 □ Divorce	If Yes, Give	lo	1f` 1 [as Decedent of H ∕es, specify Cuba ☑Yes 🏋 No	an, Mexicai Specify:	n, Puerto	ecify Yes or N Rican, etc.)			etc. uite	
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á		17. Father's Name (First, Midd Walter Ha	_{lle, Last)} allisky					er's Name rtha	(First, Middle Agachir		Surname)		
		19a. Informant's Name/Relation		1	512	Address (Street Colony Roa	ad Oxo			and	20745		
		4 ☐ Donation 5 ☐ Other			tion	tion (Name of tory or other place Cemetery	1	1/21/		Cli	cation - City or T nton, Mary	vland	
once		21. Signature of Funeral Servi	CerLicensee			Name and Address 160 Oxon $$ $$					Funeral Ho Land 20	ome PA 0745	
an al er		23a. P. 1. Enter the disease, shock, or heart failure. L'Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a Due to (as as a C.	a consequence of):):):):	ticl Fibr Mel Ersi	al.	lich	Insc.	las	DiSue	onset and Death School dr In Ima	1 & 1 A
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗀 Fetal death		Ectopic pregnanc Other <i>(specify)</i> _	у			2	23d. Date of deliv	very Day Year	
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		30. Name and address of pers 31. Date filed (Month, Day, Ye.	/scatara	780	ype, Pr	int) Arasto	3 7 20 Yazı	lani C	MIT	10 A	10 2	735	
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DHMH 17 Rev 1/2001

Registrar

Sacred Heart Home Funeral Director Funeral Director Social Security Number 6.5 sex 1 m/2 kg 7.9 ge (in yrs. last pirmfact) 1 m/2 kg 7.9 yrs. 1 m/2 kg 1 m/2	unty of Death nce George's 9. Birthplace (State or Foreign Country) Washington, DC 10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Marion Lillian Mobley Marion Lillian Mobley	8 2:00 P M unty of Death nce George's 9. Birthplace (State or Foreign Country) Washington, DC 10d. Inside City Limits 1 K Yes 2 □ No n of What Country? ed States Race - American Indian, Black, White, etc. vecify: White of Business/Industry vernment / tment of Labor rname) own, State, Zip Code) 85 ion - City or Town, State twood, MD Baltimore Avenue sville, MD 20781 Approximate Interval Between
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Usual Feeddence of Decedent 10c. County 10c. City, Town or Location 10c. State 10b. County 10c. City, Town or Location 10c. State 10b. County 10c. City, Town or Location 10c. Street and Number 10c. Street 10c. Street and Number 10c. Street and Number 10c. Street 10c	10d. Inside City Limits 1 X Yes 2 □ No 1 of What Country? ed States Race - American Indian, Black, White, etc. Pecify: White of Business/Industry vernment / tment of Labor rname) own, State, Zip Code) 85 ion - City or Town, State twood, MD Baltimore Avenue sville, MD 20781 Approximal Between
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Medical Examiner Sequentially list conditions, and the part of	10 weeks
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Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Co. Due to (or as a consequence of): 23d. If yes, outcome pf pregnancy in the past 12 months? 1	10 weeks
O. The past 12 months? Specific properties Post Pos	
O. The past 12 months? Specific properties Post Pos	
Solution of the past 12 months? 1	
O t see a se	- 17 - 2
	l. Date of delivery Month Day Year
	contribute to the cause of death?
The part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Yes 2√2 N Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Urinary tract infection Colon cancer 23e. Did tobacco use of the underlying cause given in Part II. 23e. Did tobacco use of the underlying cause given in Part II. 24a. Was an 24b.	No 3 Probably 4 Unknown
Colon cancer 24a. Wasan	24b. Were autopsy findings available prior to completion of cause of
Failure to thrive Failure to thrive Fail	death? 1 ☐ Yes 2 ☐ No
Failure to thrive To year 2 No	
To yes 2 No 1 1 1 1 1 1 1 1 1	
C = 5 = 5 1 ⊠ Natural 5 □ Pending (Month, Day Year) Injury Work?	bouried
To be the composition of the com	lumber or Rural Route Number,
Duilding, etc. (Specify) City or Town, State)	
2 Accident 3 Suicide 4 Homicide 5 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Not City or Town, State) 29g. Certifier 1	
	signed (Month, Day, Year)
2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Raman R. Tuli, 3503 Perry Street, Suite B, Mt. Rainier, MD 20712	
State Registrar NOV 1 9 2008 State NOV 1 9 2008 Registrar NOV 1 9 2008	

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician Calvin Donnell Massey, Jr. 08:05 M 05 2008 ii /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHEVERLY PRINCE LEDRGE'S HOSPITALLCENTER PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1**X**M 2□F 41 November 5,2008 None Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23e or 28e-f show the Modical Examiner must be notified at 1 X Yes 2 □ No Maryland Prince Georges Oxon Hill Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5420 Livingston Terrace; Apt. 302 20745 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than None None None permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Itam 27 is marked other til any injury or other traumatic avent, II.A. Once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Calvin Donnell Massey, Sr. Bernita Vanassa Drumgold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20745 19a. Informant's Name/Relationship (Type, Print) Bernita V. Drumgold (Mother) 5420 Livingston Terrace: Apt. 302: 0xon Hill Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov.13,2008 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory, * 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Inc. 21. Signature of Funeral Service Le 22. Name and Address of Facility N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KESPIRATORI FAILURE Physician /Medical Due to (or as a consequence of): Examiner OPLASTIC LUNGS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of SYNDROME the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed TEK Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ cate has been signated page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 X No 1 Yes 2 X No Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 🖾 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 00066998 11-05-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABBULKADIR MD PRINCE GEORGE'S HOSPITAL ADEGBOTEGA iled (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Janet Marks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Ye April 30, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 578-16-0938 92 1916|Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Interpretail: If I fleat 21 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the "hocing Exquire mail to reciffed at Director 1 Nes 2 No Maryland Prince George's Hyattsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 922 Karlson Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 🔀 No 1 ☐ Yes 2 🖾 No Specify δ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Owen Ritchey Jessie Morgart 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Creighton Marks / Son 922 Karlson Avenue, Hyattsville, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 11/18/2008 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) naamon **Physician** /Medical Due to or as a consequence of) Examiner consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform man 1 □Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Impatient Certification: To Date of Injury (Month, Day, Year) 27. Manne eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 A atural 5 Pending 1 □Yes 2 □ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Records, of Vital Division

Maryland 21215-0036

Baltimore,

and burial-tra attending physician for use as the buria page 2 s certificate funeral death.

within 24 hours after death

To the Funeral Director:
completely filled in by the

4 Homicide Medical 29a. Certifier

(Check only

State

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31. Date filed (Month, Day, Vear)

29b. Signaty / and title of certifier

701 Kando 32. Registrar's Signa

of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 38543 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Pavid Mallinak 03:05 M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medical Baltimore University of If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Min. 1 X M 2 □ F Months Hours 51 Sept. 21, Cleveland, Ohio Director 284-48-4478 1957 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experience at the mother at Directo 1 ☐Yes 2 X No Maryland Prince George's Mount Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4301 29th Street 20712 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🕅 No Specify. White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen T. Mallinak Eleanor Leonard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Walrath / Sister 17906 Glenshire Ave., Cleveland, Ohio other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ita any Injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Nov.14,2008 | Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ancer /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached f 1 ∐Yes 2 XINo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has be irector, page 2 s 24a. Was an autopsy 2 🗆 No 1 □Yes 2 1 No 1 ☐Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred Division 1 Matural 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU4176435Z18194 NOV 2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Zaidi Baltimore MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar NOV 1 7 2008 Receive Mr. Appell		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 11-9-2008 6:40P M Alan G Morrison /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs.

Months Days Hours | 14 Montgomery Holy Cross Hospital 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 11-6-1964 Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** 1 🛛 M 2 🗆 F 577/84/6558 44 Yrs Washington DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Director DC XXYes 2 □ No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 20011 USA 31 Rittenhouse St NE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 ☑ Never Married 2 ☐ Married ed other than "natural", or event, the Wedler Example Baltimore, Maryland 21215-0036 1∐Yes 2∐XNo ģ Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Program Manager District Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nould be fi Be of Health and Mental Morrison Doris L Crawford Eugene 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlton Morrison, Brother 31 Rittenhouse St NE Washington DC 20011 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glenwood Cemetery 11/15/2008 Washington DC 22. Name and Address of Facility Taylors Funeral Home 21. Signature of 1722 North Capitol St NW Washington DC 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Failure /Medical Due to (or as a consequence of) **Examiner** Hodgkins Lymphoma Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last executed AIDS and burial-tran Due to (or as a consequence of). attending physician Box 68760 certificate be Physician/Medical use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2XINo 24a Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 🔀 Natural 5 Pending Injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 □Yes 2 □No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

31. Date filed (Month, Day, Year) State NOV 1 4 2008 Registrar

Dr Hing-Churg Lee 1500 Forest Glen Rd Silver Spring, Md 20910-1484 32. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0067901

11-10-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0836 AM **Physician** 2008 Steve Miller NOV /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Medical of Maryland Center University 9. Birthplace (State or Foreign Country) Maryland Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Min. 1**X** M 2□ F Months Days Hours UNK 36 /20/1972 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evondor must be notified at YEYes 2□No Director Burtonsville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20866 U.S.A. 4605 Sandy Spring Rd by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be a Mark Stevens Miller Kathy ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4605 Sandy Spring Rd Burtonsville, MD 20366 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau
once. Mark Miller (father) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislause Nov. 14,200B Baltimore, MD 5 ☐ Other (Specify) 4 Donation 21. Signatur of uneral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lymphoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sersis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (r as a consequence of): Examine Stroke Hospital or AttendIng Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🖾 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Man or of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death.

Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after dex

To the Funeral Directo

completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AU4176435Z18194 NOV 2008

Registrar
DHMH 17 Rev 1/2001

State

Baltimore MD

21201

St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene

Zaidi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38547 State of Maryland / Department of Health and Mental Hygiene? 🔒 🗎 🤉 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 08, 2008 Physician 5:30 P M Minor Lee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fort Washington Prince George's 8112 Turner Street If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** Months 1 □ M 2 🗙 F 57 578-70-8437 07/18/1951 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Fort Washington M∑Yes 2 No MD PG Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8112 Turner Street 20744 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ **ZKN**30 If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: Black þ 3XXVidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2 years Loan Manager Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be filment of Health and Mental Heart; If Item 27 Is marked out Robert Lee Sarah Moye 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Khisa Lee - Daughter 8112 Turner Street; Ft. Washington, MD 20744 permit. Pages 1 and 3 Department of Health Important; If Item 27 any Injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 11/15/2008 Harmony Memorial Pk Landover, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services aure of Funeral Service Licenses 4594 Beech Road; Temple Hills, Maryland 20748 23a. Pal 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immedia e ause (Final disease or condition resulting in death) **Physician** Malignant Neoplasm, Eronchus and Lung, unspecified /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any the distribution in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed and use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No page 1∏ Yes 20No 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 201No 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury (Month, Day Year) 1XXII iatural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident death Director; 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital within 24 hours a Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 466665 November 13, 2008 ress of person who completed cause of death (Item 23a) (Type, Print) ASIT COURT # 200 LARGO MD State Registrar

State Registrar

DHMH 17 Rev 1/2001

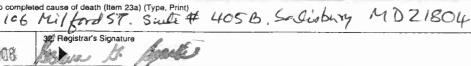
31. Date filed (Month, Day, Year) 18 2008

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Babulal Das





29c. License number

157952

29d. Date signed (Month, Day, Year)

11/03/08

State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 Nov. 12, 2:55 A M Phoebe Moak /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Montgomery 4701 Willard Avenue Apt. 714 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Dec 2, 1923 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min New York 1 □ M 2 🖫 F 156-16-2462 84 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Wodical Examiner must be notified at No Yes 2 No Director Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4701 Willard Ave #714 20815 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Event Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: à Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fashion Fashion Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Elkins Gertrude Moskowitz ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester Moak/ Husband 4701 Willard Ave, #714 Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABuria! 2 ☐ Cremation 3 ☐ Removal from State New Montefiore cem 11-16-08 New York 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature African Service Lice 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 6 Days Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Year Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinson's Disease 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy 2¥∏No 1 ☐ Yes 2 ☐ No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 ☐ Pending investigation ours after death. leral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 20297 Nov 12,2008 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James H. Brodsky, MD, PC 4701 Willard Ave #224 Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 8 2008 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

of Vital

Division

		For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of rtificate of	Health and Death	d Mental Hy	giene 2	008	38550
Physicia		1. Decedent's Name (First, Middle Karle		Mighty	1			2. Date of Do Month	Day	Year 200 Ç	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution Ellicott City He	n, give street and n				or Location of De	eath		nty of Death	ward
Funeral Director		5. Social Security Number 212-17-4140	6. Sex 1 □ M 2 🗵 F		s. last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 H	rs. 8. Date of Bi in. (Month, D	rth ay, Year) 9, 1976	Cou	place <i>(State or Foreign</i> <i>intry)</i> ict of Columbia
ne Maryland 8a-f show otified at	Director	1.017 1.01	oward	10c. C	City, Town or Lo		Laure1		100 000000		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
perfullibility in the Marylania Z I Z I J-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. I I mimortant: If item Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Dir	10e. Street and Number 11.560 Jamesto 11. Marital Status	12. Was De		U.S. 13.	10f. Zip Code Was Decedent of If Yes, specify Cu	20723 Hispanic Origin? ban, Mexican, Pu	(Specify Yes or Nierto Rican, etc.)		U.S Race - Ameri Black, White,	S.A. can Indian,
2 hours after atural", or its	δ	1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	Dates:	16a. Dece	1 ☐ Yes 2 ☑ No	upation		Spe	ec <i>ify:</i> f Business/Ir	Black
I C ICI.	Completed	(Specify only higher Elementary/Secondary (0-12) 17. Father's Name (First, Middle	4	(1-4or 5+)	- (Give	DO NOT use retir	tute Teach	-	Scl	hool Sy	e's County stem
all yiallo	To Be		Mighty, Sr	•	19b. Mailir	ng Address (Stree		Donna M. I	√alker		p Code)
ages 1 and 2 nt of Health a r: If item 27 is r or other tra		Donna M. Mig 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation	3 □Removal from	20b.	. Place of Dispo cemetery, crea	sition (Name of matory or other p	ace)	Laurel, Ma Date 1/17/2008	20c. Location	on - City or T	
permit. Pages Department of Important: If it any injury or once.		4 □ Donation 5 □ Other (: 21. Signature of Funeral Service	Licensee		ار ا ²² ابر ابا		ress of Facility II Funeral Impshire Av	Home, Inc. venue, Silv	er Sprin	hi, Mary ng, Mary	7land 20904
Physician /Medical	S 1	23a. Part1. Enter the disease, of shock, or hear faill re. Lis Immediate Cause (Final disease or condition resulting in death)	r complications that t only one cause on a.	caused the de- each line.	ath. Do not ent Us tag	ter the mode of d	ving, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
Examiner	niner	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	o (or as a conse	equence of):	Encept	alopal	ry clise	CARL		
icate be executed physician and sthe burial-transit	dical Examiner	that initiated events ' resulting in death) Last	c. Thurstone d.	o (or as a conse	equence of):			<i>(</i> , , , , , , , , , , , , , , , , , , ,			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome pf preg birth 2 □ Fe gnant at time of nown	etal death 3	⊒Ectopic pregnar ⊒ Other <i>(specify)</i>	icy		23d.	Date of deliv	very Day Year
law requires that it as been signed by 2 should be detail	þ	Part II. Other significant condit	ions contributing to	death but not re	esulting in the u	nderlying cause o	jiven in Part I.		tobacco use o		the cause of death?
The law recate has be page 2 sho	Completed							24a. Wa: auto perl 1∐ Yes	s an 24 opsy formed? 2 No	prior to or death?	topsy findings available completion of cause of 2 ☐ No
or vital hysician: 1 this certificat al director, pa	To Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:		ER/Outpatie	IL SEL DOA	ther: 4 Nursing	Death (Check only	idence 6 🗆		ify)
or Attending Phy after death. Director: After this in by the funeral c	Certification:	3 Suicide 6 Could	ng (Mo igation not be	e of Injury onth, Day Year) ce of injury - At		W]Yes 2 □ No	28d. Describe			ral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certify	ing Physician: To the	ding, etc. (Spec	<i>cify)</i> nowledge, deat	h occurred at the	time, date and pl	City or To	iwn, State) e cause(s) and	d manner as	stated.
To the Hivithin 24 To the Filton	Medical	29b. Signature and title of certific		inner stated.							. ,
,		30. Name and address of person	who completed ca	use of death (Ite	em 23a) (Typę,	Print) ed Neck	Road	Baltim	n Ma	ryland	2/22/
Sta Registi		31. Date filed (Month, Day, Year	2008	Registrar's Sig	nature God	with the same					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** William Alexander McGowan 23:41 hr. NOVEMBER 13, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1**X**M 2□ F 577-42-0483 78 JAN 25. 1930 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f shov r than "natural", or items 23a or 28a-f show Completed by Funeral Director 1 ☐Yes 2 ☑ No Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 3632 Gleneagles Drive, #3-F United States Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No Korean If Yes, Give Confli Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: Conflict 3 Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. State Department Message Center Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evone. George Bradford Ferry Moore ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3517 S. Leisure World Blvd., Silver Spring, MD 20906 Larry K. Pusey / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 X Donation 5 ☐ Other (Specify) Science Care 11/15/2008 Aurora, Colorado 22. Name and Address of Facility
Thibadeau Mortuary Services, P.A.
933 Gist Avenue, LL, Silver Spring, MD 20910 21. Signature of Funeral Service Licenses M00956 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE RESPIRATORY DISTRESS SYNDROME 36 HRS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown CHRONIC SYSTOLIC HEART FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an VENTRICULAR TACHYCARDIA autopsy perform 1 ☐ Yes 2 🎇 No 1 □ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation

or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records,

Director: To the Hospital or within 24 hours at To the Funeral D

2 Accident

4 Homicide

(Check only

29b. Signature and title of certifier

3 Suicide

29a, Certifier

Medical

6 Could not be determined

9+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIEBERMAN, M.D., 1400 FOREST GLEN RD., #200, SILVER SPRING, MD 20910 В. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 18 Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 TYes

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0051817

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

NOVEMBER 14, 2008

amend #5 Per Per FH G887 1/08/09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year **Physician** Joan Regina Mancusi 12:45 p /Medical 2008 November 14, 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 070-20-6930 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F 84 Director 070-29-6931 April 22, 1924 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner rust be inclified at once. 10a State 10h County 10c City Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2921 N. Leisure World Blvd., Apt. 216 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 TNNo Specify: ģ Specify: White 3 ₩ Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Aloysius Boylan Marguerite O'Brien ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Anne Mancusi/Daughter 6808 Pineway Street, University Park, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Nov. 14, 2008 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Hemorrhagic Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of certificate be executed sician and burial-trans Rheumatoid Arthritis Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical Hyperlipidemia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 Tho Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Q Other (Specify) 1 Yes 2 No To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Hospice 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation 1x Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Joselyne Koualchou, mi D0063747 NOV. 14, 2008 ID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, MD 6001 Muncaster Mill Road, Rockville, MD 20855 31. Date filed (Month, Day, Year) Registrar's Signature State 18 2008 Registrar VON

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4b. City, Town, or Location of Death

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2. Date of Death

November

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4c. County of Death

2008

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3. Time of Death

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Mary	nd 2 shou Ith and Iv 2 7 is mai traumai		19a. Informant's EVELYN		ship (Type. Print) SISTER		
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| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, MAY 25 Birthplace (State or Foreign Country)
 N . C . cial Security Number 6. Sex 7. Age (In yrs. last birthday) ^{Year)} 1940 1 M 2 □ F 68 39 58 4831 Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 1 XYes 2 No D.C. WASHINGTON 10g. Citizen of What Country? Street end Number 10f. Zip Code 5120 ASTOR PLACE, S.E. 20019 USA Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) farital Status 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT MANAGER 18. Mother's Name (First, Middle, Maiden Surname) ather's Name (First, Middle, Last) NATHAN NICKELSON JR. FRANCES WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 7515 VAL LANE DISTRICT HEIGHTS MD. 20747 /ELYN HALL/ SISTER permit. Pages 1 a
Department of Her
Important: If Item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State LITTLE MISSION CEM! 11/15/08 MAGNOLIA, N.C. 4 ☐ Donation 5 ☐ Other (Specify) 20010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WATSON F. H. 3435 14th ST., N.W. WASH. DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical e to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to intrinduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9□Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed res 2 X certificate 1 ☐ Yes 2 ☐ No Division or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t After Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 1, . George

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State Registrar 31. Date filed (Month, Day, Year)

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29b. Signature and title of pertition O.C.M.E. November 11, 2008 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	be exe	ğ	UNPENDED						22d Date of	delivery
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29b. Signature and title of pertition O.C.M.E. November 11, 2008 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	On candin sath.	tio	layortigation No	v 10, 2008	1715 hrs					
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O.C.M.E. November 11, 2008 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filled (Month, Day, Year) 32. Registrar's Signal re	To the to comp	Med	and ma	nner stated.						
Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		_	1000 12 12 Vall			O.C.M	M.E.		November	11, 2008
Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	a lin)		30. Name and address of person who complete	cause of death (Item :	23a)				101-100	
of Butto mod (Month), boy), out	KU			edical Examiner	111 Penn Stre	et, Baltim	ore, MD 2	1201		
Registrar NOV 1 4 2008 Keeper & April 1	S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	re of					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 Nov. 14 0606 Carl I. Olsen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Charlestown Care Center Catonsville 8. Date of Birth (Month, Day, Year, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours 1**⊠**M 2□F 718 08 9015 93 Aug 9, 1915 Director Washington DC Usual Residence of Decedent 10c City Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Director MD **Baltimore** Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 709 Maiden Choice Lane N212 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Inqwald Carl Olsen Rose Ritzenger ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2716 Links Court Ellicott City, MD 21042 Thoedore J. Olsen/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 11-17-2008 Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Dom Q 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia, Cardiomyopathy 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X** No ၉ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

certificate be executed P.O. Box 68760 Division or Vital Records, Physician:

attending physician nse jo the þ signed t page 2 s has certificate After Attending Hospital or Attendl 24 hours after death. Funeral Director: A death. the filled in by e Funeral f

28a-f show

r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at

marked other than

is 1 and 2 should be fill Health and Mental H tem 27 Is marked otl

permit. Pages 1 and Department of Healt Important: If item 2

injury or

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Physician

/Medical

Examiner

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Pages 1 tment of I

within 72 hours after

Maryland 21215-0036

Baltimore,

To the within 2.

State Registrar

Medical

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D0020040

11/14/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J Evans MD 711 Maiden Choice Lane Catonsville, MD 21228

and manner stated.

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

NOV 1 8 2008





State of Maryland / Department of Health and Mental Hygiene O O O

	1- State of Maryland / Department of Health and Merital Hygierie 2008 3855 / Certificate of Death Reg. No.													
70;-	Physicia		Decedent's Name (First, Middle, Last	it)						2. Date of De Month		Year	3. Time of I	D <i>e</i> ath
	/Medic			Helen Olk	<u> </u>					Nov.	14	2008	7:15	\mathbf{P}^{M}
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, Tow					County of Death		
20-1	· · · · · · · · · · · · · · · · · · ·	.20	2845 Foxhound Rd 5. Social Security Number 6. S	ex 7. Aq	je (In yrs. last	birthday)	EJ11	cott (8. Date of Bir		Howard 9. Birth	nlace (State or	Foreign
	Funeral Director		,	□M MEZE	51	Yrs.	Months Da	ys Hour	s Min.	8. Date of Bir (Month, Da 02–16–1	1957	NY NY	place (State or ntry)	
	ryland i how I at		10a. State 10b. County		10c. City, To	own or Loc	cation						10d. Inside City	
	ne Ma 8a-f s otiffied	cto	MD Howard		Elli	.cott								ZA 140
	with the a or 2 be no	Ë	10e. Street and Number				10f. Zip Co					en of What Cou	•	
	eath	Funeral Director	2845 Foxhound Rd	12. Was Decedent	Ever in U.S.	13. V		042 of Hispanic	Origin? (Sp.	ecify Yes or No		ted Sta		
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mential Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 [★Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes ② If Yes, Give Year or Dates:			f Y <i>e</i> s, sp <i>e</i> cify I ☐ Yes 2☐			ecify Yes or No Rican, etc.)	1	Black, White, Specify: Whi		
2-0	72 ho natur iical	ed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	1	6a. Deced	lent's Usual O kind of work d OO NOT use re	cupation	nost of work	ina	16b. Kin	nd of Business/Ir	idustry	
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Maryland	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the M	To B	Edward Racywolsk	L				Fl	orence	e Keega	n			
lar	2 sho and I is ma	ľ	19a. Informant's Name/Relationship (Town, State, Zi	,	
2	1 and 2 Health em 27 l		Thomas P. Olk/Hus 20a. Method of Disposition	sband						Date		D 21042 cation - City or T		
Jor	Pages nent of h		1 X Burial 2 ☐ Cremation 3 ☐				sition (Name on matory or other S Ceme		1			.cott Ci		
Baltimore,			4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		M01044			_	1					Tnc
ñ	The figure of the first of the control of the contr						nbia E	ike El	licot	t City,	MD 210)43		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respondence, or heart failure. List only one cause on each line.							or respiratory a	arrest,		Approximate Interval Betwoonset and D	veen		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Mercu	54471		eust a	encet					240ac	
	Examiner			,	a consequen	ice of):							,)	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequen	ice of):								
	eath certificate be executed attending physician and for use as the bunal-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequen	ico of):								
68760,	be ex sician burial	alE		Due to (or as	a consequen	ice oi).								
687	ificate g phys	edic		d										
Box	th cert ending	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy		Ectopic pregn	ancv			2	3d. Date of deliv	- ,	
P.O. B	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/N	in th <i>e</i> past 12 months? 1□ Yes 2 ∑ No 9□ Unknown	4□Pregnant a 9□Unknown			Other (specif					Month	Day Y	ear
	s that in the plant in the plan	by Ph	Part II. Other significant conditions	ontributing to death b	out not resultin	ng in the ur	nderlying caus	given in Pa	art I.	23e. Did	tobacco u	se contribute to	the cause of de	eath?
Records,	en sig	ed b								1 🗆	Yes 2	No 3□ Pro	babiy 4 □U	nknown
ec c	law re las be	Completed								24a. Was	nsv	24b. Were aut	opsy findings a	vailable use of
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Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Other:		h (Check only				
ō	Phys r this eral di	년 -	1 ☐ Yes 2XNo 27. Manner of Death	28a. Date of Inju	ury 28	Outpatien Bb. Time of		4 L Injury at Work?	Nursing Ho	ome 542 Resi		Other (Spec	ify)	
ion	nding tth. r: Afte e fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, De	ay Year)	Injury	м	Work? 1 ☐ Y <i>e</i> s 2	No					
Division or	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determin <i>e</i> d	28e. Place of in	jury - At home tc. (Specify)	, farm, str	eet, factory, of	fice		28f. Location (City or To	(Street and iwn, State)	d Number or Rui)	al Route Numi	ber,
	Hospit 24 hour Funer: stely fills	Medical (ysician: To the best niner: On the basis of and manner st	of examination)
	ro the vithin ro the comple	Mec	29b. Signature and title of certifier	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			29c. Li	cense numb	er		29d. Date	e signed (Month	, Day, Year)	
	->-0		> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	L. N.	MD			38:	509		No	v. 17,	2008	
(1) a2		30 Name and address of person who	completed cause of	death (Item 23	Ba) (Type,	Print)	1 Ph	<u <="" td=""><td>1.1</td><td>V</td><td>M</td><td>N71611</td><td>il</td></u>	1.1	V	M	N71611	il
	s Sta	ate	31. Date filed (Month, Day, Year)	32. Registi	rar's Signature	e / I	リナメルアエ	4 11	·) (/IL THUN	DING 1	i wy Jaw	W) VW	17
	Penist		NOV 1 Q	2002		A.	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** No v AULINE TRATT LODE 13:48 M /Medical 4b. City, Town, or Location of Death (If not institution, give street and number) 4c. County of Death Examiner WASHINGTON ADUCATIST HOSPITAL TAKOMA PARK CONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□ M 2 F Months Days Hours Min. 70 228-50-2903 Virginia Director Usual Residence of Decedent death with the Maryland 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exercitors roust by notified at Prince Georges Director MD Bladensburg 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 4919 Newton Street 20710 USA 23a Funeral items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🕱 No Specify: Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) Nurse 12th Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be Richard Henry Gaines Ida Beverly ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4919 Newton St. Bladensburg, MD 2071 19a. Informant's Name/Relationship. (Type. Print) Linda Pratt/daughter .00 Pages 1 and 2 of Health item 2 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem 11/15/08 Brentwood, MD 21. Sign ture di Funcial Service Li ensee 22. Name and Address of Facility 420 H Street NE BK Henry Funeral Chapel Wash DC 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEPTIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner KLEBSICULA PNEUMONIAE BALTICREMIA AND PNEUMONIA Sequentially list conditions Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed TRICUSPID VALVE ENDOCARDITIS and burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 힏 in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No. the detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by RENAL FAILURE 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown CLOSTRIDIUM DIFFICILE COLITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate | performed 1 □ Yes 2 KNo 2 □No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Natient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpat Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 K Natural death. 1 ☐ Yes 2 ☐ No 2 Accident the hours after deat uneral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours Medical 29a. Certifler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2, To the F 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

1. Date filed (Month, Day, Year)
NOV 1 8 2008

32. Registrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

WASHINGTON APURNIST HOSPITAL 7600 CARROLL ARE TAKOMA PARK

			for State Registrar	State of Mar		epartme <i>Certifica</i>				giene Reg. No. 20	08	38	559
	Physicia	an	1. Decedent's Name (First, Middle, L	ast)	-				2. Date of Dea		Year	3. Time o	f Death
	/Medic	al		aylow		41. 00		landin (D. III	11/15	5/2008		8:41	A ^M
	Examin	er	4a. Facility Name (If not institution, g Prince George's			4b. City		Location of Death		4c. County Prince		rasts	
	Funeral			Sex 7. Age (In yrs. last birth		r 1 Year	If Under 24 Hrs.	8. Date of Birt		9. Birth	place (State	or Foreign
	Director		577-30-9934	1□M 2ÑF	82 Y	rs. Months	Days	Hours Min.	8. Date of Birt (Month, Day 3/11/19	26	Çoui Wa	shingt	on,DC
	land		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town	or Location					1	0d. Inside C	City Limits
	Mary a-f sh	tor	MD Prince (George's		La	ndove	r Hills				1 XYes	2 □ No
	or 282	Director	10e. Street and Number	scorge b			p Code			10g. Citizen of V	Vhat Cour	ntry?	
	23a c	ral	3712 Warner Ave	₽.			20	784		US	SA		
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show as marked other, the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐XVidowed 4 ☐ Divorced	If Yes, Give	er in U.S.	13. Was Dece If Yes, spe 1 ☐ Yes		ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		e - Americ k, White,		
21215-0036	thour		15 Decedent's I	Year or Dates:	16a. I	Decedent's Us	ual Occupa	ation		16b. Kind of Bu			
212	e. an "na	ıplet	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)		Give kind of w life. DO NOT	ork done d use retired	furing most of work)	ting	100111111111111111111111111111111111111	01110007111	auo,	
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Maryland	be file	Be	17. Father's Name (First, Middle, Las	st)			1	18. Mother's Nam Martha	e (First, Middle, Holley		re)		
Š	hould nd Me mark matic	ပ္	Fred Chin 19a. Informant's Name/Relationship	(Time Print)	19h	Mailing Address	s (Street s	and Number or Rui			State 7in	(Cada)	
Σ	9 € 12 €		Phyllis Owens/Da	, ,,	1	-	rner		ndover F			20784	
Baitimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		20b. Place of I cemetery. Resurr	Disposition (Na crematory or ection		: 11//	Date 1/2008	20c. Location - Clinton	-	wn, State	
Ball	permit. Depart Import any inj		21. Signature of Fyner J Salan Lor	ensee				ss of Facility J.:				Home	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List onl	y one cause on each line.					or respiratory ar	rest,		Approximat Interval Bet Onset and	tween
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Melignar Due to (or ds a c	t Card	rac dys	ryth	nq					
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200	rtificat ng phy as the	ledical											
O. Box	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours aftered at the tribin set of the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2[4 □ Pregnant at tir 9 □ Unknown	Tetal death	3 ☐ Ectopic 5 ☐ Other (s		/		23d. Dat Mo	e of delive	-	Year
7.	s that the	y Phy	Part II. Other significant conditions		not resulting in t	he underlying	cause give	en in Part I.	23e. Did to	bacco use contr	ribute to th	ne cause of	death?
	equire een siç ould b	ted t	Atrial februllation) Th		_			1 🗆 Y	es 2 DNo	3 ☐ Prob	ably 4□	Unknown
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VII a	n: Th ificate vr. pag		25. Was case referred to medical	accident						2 N o 1	death?	2 🗆 No	
>	/sicia s cert lirecto	To Be	examiner?	Hospital:	2 ER/Out	nationt 3 🗆 D	OA Othe	26. Place of Deat	h <i>(Check only or</i> ome 5 ☐ Resid		0= /0===/		
DIVISION OF	nding Phy th. : Atter thi : funeral (tion: T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Y			28c. Injury Work		28d. Describe h			<i>y)</i>	
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	e Hospite 24 hours e Funera letely fille	Medical C	29a. Certifier (Check only one) Certifying F	Physician: To the best of raminer: On the basis of each and manner stated	xamination and	death occurred for investigation	d at the tin	ne, date and place, pinion, death occur	and due to the ored at the time, or	cause(s) and madate and place, a	anner as s and due to	stated. the cause(s	s)
	Vithir comp	Me	29b. Signature and title of certifier				c. License		2	29d. Date signed	d (Month,	Day, Year)	
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P	13		30. Name and address of person who Nilh Am Boyce		th (Item 23a) (T 001 Hos		Dr.	Cheverl	y, MD 20	785			
	Stat Registra		31. Date filed (Month, Day, Year) NOV 1 9 2008	32. Řegistrar's	Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 6:15 PM 17, 2008 November STEPHEN M.PRUE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CENTER CLINTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Feb. 1, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 11 M 2□ F 579-88-5171 40 Washington, D.C Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Medical Examiner must be notified at 1 AYes 2 No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with Funeral 2nd Street N.W. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black Saltimore, Maryland 21215-0036 1 □Yes 2 No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ene. Elementary/Secondary (0-12) College (1-4or 5+) N/A d 2 should be filed w th and Mental Hygier 7 is marked other th Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margo Allen Stephen Allen Prue ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traus 4528 Livingston Rd. S.E. #C Washington, D.C. 20032 Stephen Allen Prue / Father 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National | 11/22/2008 | Suitland, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Alexander Strong, P. A. Lexander Strong, P. A. Lexander Strong, P. A. S. E. Washington, D. C. 20020 S. E. Washin Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or a a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed ng physician and as the burial-transi Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the a 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 sl performe this certificate of Vital 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 မှ 1 mpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 1 Anatural 2 Accident 28b. Time of 28d. Describe how injury occurred After Certification: Division or Attending 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

William 31. Date filed (Month, Day, Year) State NOV 2 0 2008 Registrar

29b. Signature and title of certifier

11701 Ci Vingstra 32. Registrar's Signat

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 17, 200 **Physician** ornelious ovember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner choverly Ceorges HOSP, Tak If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 250-54-1997 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits other traumatic event, the Medical Examination to notified at ¥ZiYes 2 □ No mitche. Il VI 11e Director MD 10e. Street and Number 10g. Citizen of What Country? GOIF COUYSE 207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No 1ack Specify δ. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) WOYKEY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luberta 1411 BOIF COURSE Drive Mitchell Ville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o once. Burial 2 Cremation 3 Removal from State Lauvel, MD mD National cem. 11-22-2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bianchi 814 Upshur St NW Wash, & 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Parkinsons disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine nding physician and use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certification: Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, e Hospital or Attending P 24 hours after death. e Funeral Director: After t within 24 hours a

To the Funeral C

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

300/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29a. Certifler

(Check only one)

ca

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#8.PerFHPGC11-17-08cr Certificate of Death Reg. No. 🦾 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** PARTAIN DORIS NOVEMBER 0429 11 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1944 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days 64 Yrs. Director 577-56-8540 12,1944 West Virginia Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits or 28a-f shown notified at Director ☐ Yes 2 ☐ No Maryland Prince Georges <u>Hyattsville</u> the 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country ò death with r items 23a or iner must be r 5607 Decatur St 20781 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2√2 No Specify. 2 3√2 Widowed 4 □ Divorced Specify: Year or Dates: "natural", White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Output

Description: Decedent's Education 16b. Kind of Business/Industry Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Self Employed Florist pe filed event, 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecil Ray Fox is marked Cordie Maxine Moore ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Arnold of Health of Health 27 i (daughter) 274 S. Dale St. Dunkirk, MD 20754 20b. Place of Disposition (Name of cemetery, crematory or other place.

ID. Nat. Cemetery 20a. Method of Disposition Pages 1 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any Injury or ott 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 18,2008 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Funeral Service Licensee 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition ONE WEEK **y/Medical** resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and d for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for a in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 > Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) .cal or Ats.
.ours after death.
.=al Director; After this .
. '> by the funeral dir 1 ☐ Yes 2 No ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 me NOVEMBER 11 ZOOX

Registrar

State

10

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

A. REISS

31. Date filed (Month, Day, Year)

NOV 1 7 2008

Certificate of Death

4b. City, Town, or Location of Death

38563

3. Time of Death

15:43

Reg. No.

4c. County of Death

Date of Death
 Month

11-04-08

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

PRISCILLA O.

4a. Facility Name (If not institution, give street and number)

PARHAM

مبد			Washington				oma Par		Montgo	mery			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1										
	Director		579-36-2524		70 1	rs.		4/10/	30 Was	hington,DC			
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	ems erm	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S.	Was Decedent of F If Yes, specify Cub:	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh				
36	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show Joal Examilier must be coffeed at	by F	1 Never Married 2 Married	1 ∐Yes 2¥∑ No If Yes, Give		1 ☐ Yes 2 📉 No	Specify:		Specify: B				
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Maryland	be d o	00	James Stroud	,			Amy Mc		······,				
Z	12 should th and Mer 7 Is marke traumatic	ဥ	19a. Informant's Name/Relationship	/Time Print)	10h	Mailing Address (Street	and Number or Di	ural Pauta Number	City of Town State	Zin Cada)			
Ma	tra tra		Norma L. Tayl		1	910 Barne							
	s 1 and 2 of Health item 27 I other tra		20a. Method of Disposition						20c. Location - City o				
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ij.	mit. Pag partment cortant: Injury c		4 ☐ Donation 5 ☐ Other (Spec		Herit	age Mem.							
Baltimore,	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lice	n608					•	uneral Home			
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			3a. Part 1. Enter the disasse, or conshock, or heart fallere. List only	plications that caused the one cause on each line.	death. Do no	ot enter the mode of dyin	ng, such as cardia	or respiratory arre	est,	Approximate Interval Between			
I.	Physician		Immediate Cause (Final disease or condition	SEP	110	SHOC	K			Onset and Death			
	/Medical		resulting in death)	Due to (or as a co	onsequence of): TA 24	00111						
	Examiner		Sequentially list conditions				PONA	DE					
	Φ .±:	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of	JALVE	=NDO	DO NI	TIC				
6	ecute ind trans	am	Cause (Disease or injury that initiated events				٥٩٥٥	711-01	115				
oʻ	uires that the death certificate be executed is signed by the attending physician and Id be detached for use as the burial-transit		resulting in death) Last	Due to (or as a co): DVASCUL	na A	1/1/18	_ 1-1				
Box 68760,	ate b hysic the b	Physician/Medical	•	d. CEIC	EDU	MASCUC	ATIC P	4 CIDE	101				
9	ertific ing p e as	Mec	IF FEMALE:										
ရွိ	ath or ttend	an/	23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		3 ☐ Ectopic pregnanc	ey		23d. Date of d	elivery Day Year			
o	e de; the a	sic	in the past 12 months? 1 ☐ Yes 2 ☒ No	4 ☐ Pregnant at tirr 9 ☐ Unknown	ne of death	5 ☐ Other (specify) _			Month	Day Teal			
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Division of Vital Recor	Physiclan: The law req this certificate has beer ral director, page 2 shou	Complete	PARKIN	son's p	DISTE	ALE		perforn	ned? death?				
ita	siclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one	·				
>	ysic nis ce dire	2	1 Yes 2 1 No	Hospital: 1 Impatient	2 ER/Out	oatient 3 □ DOA Oth	er: 4 🗆 Nursing H	lome 5 Reside	ence 6 Other (Sp	ecify)			
0		ä	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye	28b. Ti	me of 28c. Injui	y at k?	28d. Describe ho	w injury occurred				
<u>Ö</u>	Attending r death. ector: After by the fune	atic	2 ☐ Accident investigation	n	,,		Yes 2 □No						
<u> </u>	r Atte er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not 6 ☐ Homicide determined		- At home, farr	n, street, factory, office		28f. Location (St. City or Town	reet and Number or F	Rural Route Number,			
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying F	hysician: To the best of m miner: On the basis of ex	ny knowledge,	death occurred at the ti	me, date and place	e, and due to the coursed at the time	ause(s) and manner	as stated.			
	the H in 24 he F hplete	Medical	one)	and manner stated	,	, or investigation, in fily t	ophillori, death occi						
	To the most	Σ	29b. Signature and title of certifier			29c. Licens		25	9d. Date signed (Mor	oth, Day, Year)			
	2		▶ SWAMIU				59284						
		Ì	30. Name and address of person who	completed cause of death	n (Item 23a) (1	ype, Print)		^ == a:	1 Da-2 : :	112-2011			
			30. Name and address of person who	MICH, WASY	40610	IN ADVENT	2 (408	TAKON	MALLINA	, 49-20112			
	Sta		31. Date filed (Month, Day, Year)	Registrar's	Signature	1 15							

			For State	State o	f Marylan		artment of h	Health and N		2000	38564
			Registrar 1. Decedent's Name (First, Midd	tle. Last)		001		Dealii	2. Date of Deat	og. 110.	3. Time of Death
	Physic		Calvin Russell						Month November	Day Year	9:42 aM
	/Medi Examir		4a. Facility Name (If not institution	on, give street and nu	mber)		4b. City, Town, o	or Location of Death		4c. County of Death	
9			Suburban Hospita	1			Bethes	eda.		Montgomery	,
	Funeral		5. Social Security Number	6. Sex 1 X M 2 □ F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign
	Director		228-30-1315	IAC W ZUF	79	Yrs.			May 17,		
	and		Usual Residence of Decedent 10a. State 10b. Count	/	10c. City	, Town or Lo	cation				10d. Inside City Limits
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	the Maryland r 28a-f show notified at	Director	Maryland M 10e. Street and Number	ontgomery		Kensin	10f. Zip Code		1:	0g. Citizen of What Cou	ntry?
	3a ol	O E	3112 Ferndale	Street			20895			USA	,
	ours after death with ral", or items 23a or Examinat must be	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.S	S. 13.		Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
9	after or ite		1 ☐ Never Married 2 ☐ Ma		2 🗌 No		it Yes, specify Cub. 1 □ Yes 2 1 € No		Rican, etc.)	Black, White,	
93	ours iral",	d by	3 Nidowed 4 ☐ Divorce	If Yes, Given Year or D	ates: Korea: Confl	11	ILLIES ZALINO	Specify:		Specify: Whit	æ
<u>~</u>	72 h "natu	lete	15. Decede (Specify only high	nt's Education est grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of work d)	ing	16b. Kind of Business/Ir	ndustry
5	within ene.	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	270		d)		D-1-17 G 7	
d 2	Hygid Hygid ther		17. Father's Name (First, Middle	. Last)		PELLE	ager	18. Mother's Name	e (First Middle N	Retail Sale	<u></u>
an	d be ental ked o	To Be	James Robert Powe	,				Bettie St		aldon ourname)	
Maryland 21215-0036	and 2 should be filed within 72 hours after death with the Maryland alth and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show a traumatic event, the Mackal Exprine must be notified at	F	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailir	ng Address (Street			City or Town, State, Zi	n Code)
ž	2 C in in		Gail Manner/Daug	hter		3112	Ferndale S	Street, Kens	ington, MI	20895	,
altimore,	permit. Pages 1 and Department of Heatth Important: If item 27 any injury or other tonce.		20a. Method of Disposition		20b. Pl	lace of Dispo	sition (Name of natory or other place	(ac		20c. Location - City or To	own, State
<u>Ĕ</u>	Pages nent of ant: If its ury or o		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (3		State I		an Cremator		08	Alexandria, V	irginia
alt.	permit. Departr Importa any inju	Πġ	21. Signature of Funeral Service	Licensee		22	. Name and Addre	ss of Facility bllins Fune	ral Homo I	ina	
Δ.	80 = 9		- Cinchen) Hole		50	00 Universi	ty Blvd. W.	, Silver S	pring, MD 209	01
9	Physician /Medical Examiner	ər	23a. Part 1. Enter the disease, o shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if the level health immediate.	aDue to (or as a consequence or a consequence o	ligh Hence of): Levet	Infarc Caron	ction		ects e	Approximate Interval Between Onset and Death
9449 68760, CT	rificate be executed ig physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	or as a consequ						
15/08 09 s, P.O. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	come of pregnar pirth 2 Fetal nant at time of de own	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deliv Month	ery Day Year
S, F	ss tha gned	y P	Part II. Other significant conditi	_	eath but not resu	lting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
= pro	equire sen si ould b	ed	Parkin son Dis	ease,					1 □ Ye	s 2 XINo 3 ☐ Prol	bably 4 Unknown
(A √Ì) II	To the Hospital or Attending Physician: The law n within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh		Hypertensio 25. Was case referred to medica					OC Plans of Decade		prior to co death? No 1 \(\sum Yes\)	opsy findings available impletion of cause of 2 No
- 000-	yslcia s cer direct	o Be	examiner? 1 ☐ Yes 2 🔁 No	Hospital:	npatient 2 🛣 E	ER/Outpation	t 3 DOA Oth	er:		nce 6 □Other <i>(Speci</i> i	
	g Phy ter thi	ä	27. Manner of Death	28a. Date o	of Injury	28b. Time of	28c. Injur Work		28d. Describe how		<u></u>
Powe (ath. rr: Aff	atio	1 Accident 5 ☐ Pendir	ng (Mont gation	h, Day, Year)	Injury		K? Yes 2 □No			
Powe (vital or Atte urs after de ral Directo lled in by tt	Certification: To	3 ☐ Suicide 6 ☐ Could detern	nined 28e. Place buildir			eet, factory, office		Cify or Town,	ŕ	
	the Hosp hin 24 hou the Fune upletely fi	Medical	one)	examiner: On the ba	asis of examinati	vledge, death ion and/or inv	estigation, in my o	ppinion, death occurr	ed at the time, da	use(s) and manner as s te and place, and due to	o the cause(s)
	*	~	29b. Signature and title of certified	() //	- 000		29c. Licens	. 4		d. Date signed (Month,	
	10+1		Jenes	Man	m, MD		NOO.	イャンノフ	1	10 km bez, 15	, य००४
			Name and address of person	who completed cause	e of death (Item byrban l	23a) (Type, F	(8600	old George	selown a	d., Betheida	MD 208/4

Registrar



			State of Maryland / Department of Health and Mental Hygiene - State Registrer Certificate of Death Reg. No. 2 0 0 8 3 8	565					
			1. Decedent's Name (First, Middle, Last) 2. Date of Death						
	Physici		ROBERT E. PERRY Month Day Year NOVEMBER 14, 2008 11:45	A M					
-	/Medio Examin	_	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death						
	Examili	C-I	Bedford Court Nursing Facility Silver Spring Montgomery						
	Funeral		5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year 1 f Under 24 Hrs. 8, Date of Birth 9, Birthplace (State	or Foreign					
	Director		055-03-0671 1 M 2 F 89 Yrs. Months Days Hours Min. (Month, Day, Year) Country) New York						
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside 0	City Limits					
	aryla shov	٦	1 TVe	s 2 No					
	he M.	Director	Maryland Montgomery Silver Spring						
	with the Maryland a or 28a-f show Log notified at	ä							
	s 23	eral	3701 International Drive 20906 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,						
36	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-f show ont, the Medical Evaninet must be notified at	by Funeral	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Specify: Specify:						
Baltimore, Maryland 21215-0036	"natural", or	p p							
5	n 72 "nat	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired)						
12	withi iene. thar	E O	Elementary/Secondary (0-12) College (1-4or 5+) 4 Civil Engineer Steel						
d 2	filed Hygi Sther ent, L	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)						
<u>a</u> n	ental ked c	To B	Emilo Perinovich Michelena Iaccarino						
<u>~</u>	shoul nd M mar		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Š	nd 2 alth a alth a 27 is		Richard Perry, son 1030 Green Hill Farm Road, Reisterstown, MD 21136						
<u>5</u>	f Heg		20a. Method of Disposition 20b. Place of Disposition (Name of Semestry of State Seme						
ě	Page: ent o nt; If		1 △ Burial 2 □ Cremation 3 △ Removal from State 4 □ Dopation 5 □ Other (Specify) Magnolia Cemetery 11/20/2008 DeFuniak Springs, F10	orida					
ij	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, I'm Mance.		21. Signature of Funeral Service Ucensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.						
ä	lmp any		11800 New Hampshire Avenue, Silver Spring, MD 20904						
			23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately a shock or heart failure. Let only one cause on each line.	ate etween					
	Physician		Onset and	1 Death					
	/Medical		disease or condition resulting in death) Intracranial Bleeding Due to (or as a consequence of):						
	Examiner								
	77	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
6	cuted nd ransil	Examiner	that initiated events						
oʻ,	e exe ian al ırial-t		resulting in death) Last Due to (or as a consequence of):						
8760,	Attending Physician: The law requires that the death certificate be executed in death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	dical	d						
9	ing p	Mec	IF FEMALE:						
Вох	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	Year					
	at the de by the a tached f	sic	1						
P.0	hat the	Æ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of	f death?					
Division of Vital Records,	ires that signed I d be det	Š	Hypertension 1 □ Yes 2 □ No 3 □ Probably 4 ☑	Unknown					
ő	w requir s been si should I	Completed							
3ec	has le 2 s	ם		s available cause of					
a	iclan; The certificate hector, page		1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No						
ΖΞ	sician; certific rector,	B	25. Was case referred to medical examiner? 1□ Yes 2 ⋈ No Hospital: 1□ Innatient 2□ F8/Outnatient 3□ DOA Other: 4 ⋈ Nursing Home 5□ Residence 6□ Other (Specify)						
ō	Phys rthis raldii	P.	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify)						
o.	ding F h. After funera	ig	1 🖸 Natural 5 ☐ Pending (Month, Day, Year) Injury Work?						
is	vtten deat ctor: y the	lica	Z Acquein 6 Could not be	ımber,					
<u>S</u>	lor A after Dire	Certification: To	3 Suicide 4 Suicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Nu City or Town, State)						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	;(s)					
	orthe	Me	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)						
	(A)		Nilkenner J Ninala D45285 November 17, 2008						
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						
	•		Wilkinson Ninala, M.D., 344 University Blvd., Suite 113, Silver Spring, MD 20901						
	Sta	ite	31. Date filed (Month, Day, Year) Pregistrar's Signature						
	Regist		NOV 18 2008 J. Janes J. Appelle						

DHMH 17 Rev 1/2001

			For State Registrar		State of M	larylan		rtment of tificate of				Iene .g. No?	nΩ	32566
	Physicia	an	Month Day Year								3. Time of Death			
	/Medic	al	Beatrice W. Reynolds 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D								NOVEMBE		2008 ty of Death	8:4UAM M
	Examin	er		LIGHT CO		/		EASTO		o. Bouil			TALBOT	
	Funeral		5. Social Security I	Number 6.5			last birthday)	If Under 1 Year Months Day	r If Unde	r 24 Hrs. Min.	8. Date of Birth (Month, Day,			ace (State or Foreign
ń	Director		226-98-2 Usual Residence of	032	I L IVI ZLA	91	Yrs.				JAN 20,	1917		PA
	yland low at		10a. State	10b. County		10c. City	y, Town or Loc	ation					10	Od. Inside City Limits
	e Mar la-f sh tiffed	Director	MD	TAI	LBOT		EASTO	N						1XYes 2 No
	with th	Dire	10e. Street and Nu		ATTI			10f. Zip Code			11	Dg. Citizen of		try?
	ns 23	Funeral	11. Marital Status	ST EARLE	12 Was Deceder	t Ever in U.	S. 13. W		601 Hispanic O	rigin? (Spe	cify Yes or No- Rican, etc.)	14. Ra	JSA ace - America	
2	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If the alth and Mental Hygiene. And T is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Mar	ried 2 Married	Armed Forces 1 Yes 2 2	s? ¶No		Yes, specify Ci			Rican, etc.)	Spec	ack, White, e	
	hours tural", al Exa	d by	3 Widowed	4 ☐ Divorced 15. Decedent's E	Year or Dates	:		ent's Usual Occ				16b. Kind of	MUT	
2	in 72 n "nat Nedica	plete	(Spe	cify only highest gr		, 5.±)	(Give k	aind of work dor NOT use reti	e durina mo	st of workin		TOD. KING OF	Dualifeaanifu	ustry
7	d with giene er tha , the f	Completed	12	oridary (0-12)	3		H(OMEMAKE	R			OWN	HOME	
	be file	Be		(First, Middle, Last	,						(First, Middle, N	Aaiden Surna	ame)	
ı yıc	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	٩		S. WENTY			19b. Mailing	Address (Stre		ADYS	HART I Route Number	City or Tow	n. State. Zin	Code)
2	1 and 2 s Health an em 27 is i				ILTON/DAU	JGHTER					DR., CLA			
, G	es 1 a of Hear fitem ir othe		20a. Method of Dis		Removal from Stat		lace of Dispos	ition (Name of atory or other p	i			20c. Location		
=	Pages tment of I tant: If ite		4 ☐ Donation	5 ☐ Other (Speci	fy)	CHE					1/18/200	8 STEV	/ENSVI	LLE, MD
0	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of F	uneral Service Lice	MERCE	croi	FE	Name and Add LLOWS, O S. HA	HELFEN	BEIN	& NEWNA	M FUNE	RAL H	OME PA
ı			shock, or he	art failure. List only	pplications that cause one cause on each	ed the death	n. Do not ente	r the mode of d	ying, such a	s cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
, I	Physician /Medical		Immediate Cause disease or condition resulting in death)	on		uma								3 weeks
	Examiner			- (Due to (or a	is a consequ	uence of):	110						
Į.		ner	Sequentially list of if any, leading to it cause. Enter Und Cause (Disease of the sequential of the se	onditions, mmediate erlying	b. Due to (or a	is a consequ	uence of):	0 0						
	ecuted and transi	Examiner	Cause (Disease of that initiated event resulting in death)	.5	c. Der	merte	الما							3 years
0/00,	icate be executed physician and s the burial-transit	al E	, , , , , , , , , , , , , , , , , , , ,	l	Due to (or a	is a consequ	derice or).							
000	ificate g phys as the	edical												
5	th cert tending r use a	an/M	IF FEMALE: 23b. Was deceded		23c. If yes, outcom			Ectopic pregna	ncv			l l	ate of delive	
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	in the past 12 1 ☐ Yes 2 9 ☐ Unknow	No	4□Pregnant 9□Unknown	at time of d		Other (specify)				,	/lonth	Day Year
	that the ed by detac			7.0	contributing to death	but not resu	ulting in the un	derlying cause	given in Part	I.	23e. Did tob	acco use co	ntribute to th	e cause of death?
ecords,	quires en sign uld be	ed by									1 □ Ye	es 2 No	3 ☐ Prob	ably 4 ∐Unknown
ב ב	law re as bee 2 sho	Completed	144-141-141								24a. Was a		. Were autop	osy findings available npletion of cause of
ב ה	ding Physician: The lav. After this certificate has funeral director, page 2	Com									perforr	ned? 2 No	death?	2□ No
N I G	siclar certifi rector	Be c	25. Was case refe examiner? 1 ☐ Yes 2 ☐		Hospital: 1 ☐ Inpa	tiont O	ER/Outpatient	2[] DOA			(<i>Check only on</i> me 5 ☐ Reside			ASSISTED
5	g Phy er this ieral d	n: To	27. Manner of Dea	nth	28a. Date of Ir		28b. Time of Injury	28c. Ir			ne 5∟ Heside 28d. Describe ho			LIVING
201	endin eath. or: Aff	atio	1 ☑Natural 2 ☐ Accident	5 ☐ Pending investigation 6 ☐ Could not be	n			M 1	☐Yes 2☐]No				
Š	al or Att s after de il Direct d in by	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	Zoe. Flace of t	njury - At ho etc. <i>(Specif</i> j	ome, farm, stre y)	et, factory, offic	e	2	28f. Location (St City or Towr		nber or Rura	l Route Number,
	To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical C	29a. Certifier (Check only one)		hysician: To the besiminer: On the basis and manner:	of examina								
	To the complete compl	Me	29b. Signature an	d title of certifier	1	/			nse number		2	9d. Date sigr	1	
	TLS			5 Will	in Stth	- CA	NU	RI	2619	8		11/17	1200	δ
	a		30. Name and add	> /	completed cause of B	LKIA	1-8	Frint) 579	Com	mer	u Du	# 10	c, Eas	a sex
	Sta Registr		31. Date filed (Mo	nth, Day, Year)	008 32 Regis	strar's Signa	ture dos	ule						

5	0	-	1	day
3	0	0	O	i

		1 - For State Regist
		1. Deceden
Physicia /Medic		CARI
Examin		4a. Facility I
		South
Funeral		5. Social Se
Director		578 62
70		Usual Resid
land		10a. State
the Maryland 28a-f show notified at	ector	MD
£ 8 9	ம	10a Stroot

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Evaminer must be n

Baltimore, Maryland 21215-0036

Physicia /Medica

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Regi

1 - State Registrar		, ,	C	erti	ficate of	Death		Reg	No.			
Decedent's Name (First, Middle, Last	st)						2. Date of	Death			3. Time of D	Death
CARLOTTA	R.	ROBIN	SON				Novemb	er	13	2008	20:39	Рм
4a. Facility Name (If not institution, give		er)		4	b. City, Town, or	r Location of E	Death			nty of Death		
Southern Maryland	l Hospita	.1			Clinto	n		İ	Prin	ice Geo	orges	
Social Security Number 6. S		Age (In yrs. le	ast birthd		f Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Min. (Month,	Birth	ear)	9. Birthp	place (State or	Forei
578 62 1080	□ M 2XDXF	82	Yrs	s. "	nontina Buya	liouio	05 14				Carol	ina
Usual Residence of Decedent		10- 0:4	. T	-1						14	0d. Inside City	. Limit
10a. State 10b. County 10b. Prince (Corres		, Town or iitla		ION					'	1 ☑ Yes	
FID FILITEE C	eorges											
10e. Street and Number					10f. Zip Code			10g		of What Coun	ntry?	
4901 Braymer Ave	enue				20	746			υ.	S.A.		
11. Marital Status	12. Was Decede Armed Force		S. 1	13. Wa If Y	s Decedent of H	lispanic Origin an, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-		Race - Americ Black, White, e		
1 Never Married 2 Married	1 ∐Yes 2≱ If Yes, Give	MNo			Yes X IXNo	Specify:			Spe		LACK	
3☐Widowed 4☐ Divorced	Year or Date	s:										
15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. De	eceder Sive kin	it's Usual Occup of of work done of NOT use retired	ation during most of	working	16	b. Kind of	Business/Ind	dustry	
Elementary/Secondary (0-12)	College (1-4								Cox	/ernme	nt	
12th	2yrs.		50	ocıa	ıl Worke			" 44				
17. Father's Name (First, Middle, Last)	_					Marie	Name (First, Midd	iie, mai	aen Surn		oomer	
Charles Edward	Brown		т									
19a. Informant's Name/Relationship (1	0	,		or Rural Route Nur		,		•	
Jacqueline M. Rob	inson/Dau	ıghter	4901	1 B1	caymer A	venue	Suitland	, M	aryla	and 20	/46	
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Domoval from Sta	20b. Pi	lace of Di emetery, o	ispositi <i>cremat</i>	on (Name of ory or other plac	e)	Date	20	c. Locatio	on - City or To	own, State	
4 □ Donation 5 □ Other (Specif			rmony	у Ме	emorial	Park 1	1-22-08	La	ndov	er. Ma	rvland	
21. Signature of Funeral Service Cicer	nsee ///	11		22. N	lame and Addre	ss of Facility J	ohn T. Wa	hin	es Fi	uneral	ДАТР I	LC
1/11/11/20	nelle			300)5 12th	Street	N.E. Wa	snı	ngto	n, DC	20017	
Imprediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to humanistic cause. Enter Underlying Cause (Disease or injury that initiated events a. Due to (or as a consequence of): Performance of the conditions of the condition										_		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or d	me of pregna	ncy	3□E	ctopic pregnanc				23d.	Date of delive	-	ear
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown												
performed perfor										b. Were auto prior to co death? 1 □ Yes	opsy findings a mpletion of ca	vailab use of
25. Was case referred to medical examiner?	Hospital:				lo:	ori	Death (Check on					
1⊡Yes 2□No	Hospital: 1 Inp			3 DOA Oth	4 🗆 (14d) 5)	ng Home 5 ☐ R				fy)		
27. Manner of Death 1	1	Injury Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Description M 1 ☐ Yes 2 ☐ No					Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building	Injury - At ho , etc. <i>(Specif</i>)	me, farm,	, street	, factory, office		28f. Location City or	n (Stree Town, S	et and Nu State)	imber or Rura	al Route Numb	ier,
29a. Certifier (Check only one) Certifying Pf Certifying Pf Medical Exam	nysician: To the be miner: On the bas and manne	is of examinat										
29b. Signature and title of certifier					29c. Licens	e number		29d	. Date sig	ned (Month,	Day, Year)	
) hm					Do	064	055		17/	15/0	3	
30. Name and address of person who	completed cause	of death (Item	23a) (Ty	pe, Pri	nt)		0, 1		.00	ن در نم	-n-	
Enc medan	ald 7	502	C	111	atte	SKC	Chot	00	111	0 30	013	7
31. Date flod (Month, Day, Year) 1 9 2008	32. Reg	istrar's Signat	ture	15							-	

			For State Registrar	State of	Marylar	•	artment of F			iene	18	38568
	Di		1. Decedent's Name (First, Middle,	Last)					2. Date of Deat Month		Year	3. Time of Death
	Physici /Medic		CLAUDETTA	NOVEMBE	R 9 20	08	6:35 P M					
	Examin	er		cility Name (If not institution, give street and number) 4b. City, Town, or Location of Death							of Death	an or La
			1786 VILLAGE GE 5. Social Security Number			. last birthday	LANDOV If Under 1 Year				9. Birthpl	ORGE Sace (State or Foreign
	Funeral Director		218-90-6458	1 ☐ M 2 🖾 F	46	Yrs.	Months Days	Hours Min.	(Month, Day,		Count	HINGTON, DC
	P		Usual Residence of Decedent		10-0	ity. Town or L						Od. Inside City Limits
	shov	2	10a. State 10b. County								10	1 XYes 2 No
	28e-f	Director	MD PRINCE 10e. Street and Number	E GEORGE'S		LANDOVE	10f. Zip Code		10	Og. Citizen of W	/hat Coun	
	3a or		1786 VILLAGE GE	REEN DRIVE			20785	5		USA		(c)
	death ms 2	Funerai	11. Marital Status	12. Was Deced	ent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race	- America	
9	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show disal Exarcil set must be multified at	Full	X Never Married 2☐ Marrie				1 ☐ Yes 2 No	Specify:	o nican, etc.)		k, White, e	
003	72 hours "naturel", dical Exb	d by	3 Widowed 4 Divorced	Year or Dat	es:	1 10 5						
15	n 72 ho "natur velical	Completed	15. Decedent' (Specify only highest	grade completed)		(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of wor	rking	16b. Kind of Bu	siness/ind	lustry
212	d within 7. piene.	E O	Elementary/Secondary (0-12) 12th	College (1-	4or 5+)	FED	POLICE (FFICER		GOVER	NMEN7	ľ
פ	be filed stal Hygid od other event, ti	Be C	17. Father's Name (First, Middle, L	ast)				18. Mother's Nar	ne (First, Middle, A	Maiden Sumame	э)	
ylaı	2 should be and Mental Is marked of eumatic eve	To	CLAUDIE LEE RE	EID				HENR	IETTA JO	ONES		
Maryland 21215-0036	and and ls m		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ing Address (Street	and Number or Ru	ıral Route Number,	City or Town, S	State, Zip	Code)
	1 and 2 Health tem 27	3	LAVERNE PALMER 20a. Method of Disposition	R/FRIEND	20b.	1786	VILLAGE osition (Name of	GREEN DR		IVER, MAI		
Baltimore,	m O		1 X Burial 2 Topemation		tate	cemetery, cre	matory or other place					
ij	그 토론를 .		* 4 □ Donation 5 □ Other (So 21. Signature of Fueral Service L		1		2. Name and Addre		J. B. JEI	BRENTWOO		
Ba	Depa Impo eny ii		(D)	1		7	474 LANDO					20785
	E (1)		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that ca	used the dea	ith. Do not en	ter the mode of dyir	ng, such as cardia	or respiratory arre	est,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	*		inomo	anknuor	primary	meta strace	sis hobo	re	Onset and Death 7 mouth
	/Medical Examiner		resulting in death)	a.	r as a conse			1				
н	Lammer		Sequentially list conditions	b	r as a conse	Par	raytope	nia			2	- mouth's
	ted nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	A	\$ 10 G	o from	hive o	f femu	Λ	2	2 months
	be executed sician and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (o	r as a conse		- 1140	00014	(Kirac		_	3
8760,	hysicial	dicall		d								
9	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Aedi	IE ECHALE.							1		
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Fet	tal death 3 [⊒Ectopic pregnancy	/		23d. Date Mon	e of deliver	ry Day Year
0.	by the all	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregna 9□Unknov	nt at time of	death 5	Other (specify)					
ο.	that the ed by detac		Part II. Other significant condition	ns contributing to dea	ith but not re	sulting in the o	underlying cause giv	en in Part I.	23e. Did tob	acco use contri	ibute to th	e cause of death?
ds,	uires sign	d by							12	s 2 No	3 🗌 Proba	ably 4 □Unknown
00	> 10 0	olete							24a. Was a	n 24b. W	Vere autor	osy findings available
Be	he e h age	Completed							autops perform	y ned? d	rior to con eath?	npletion of cause of
Vital Record	ilen: T artificat ctor, pa	Be C	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only on			21
of V	Physicien: this certific ral director,	To	1 ☐ Yes 2 💢 No	-		☐ ER/Outpatie		4 Nursing F	lome 5 🔀 Reside)
		ion:	27. Manner of Death 1 XNatural 5 ☐ Pending		Injury , Day Year)	28b. Time of Injury	Wor	k?	28d. Describe ho	w injury occurre	∌d	
Division	ten deat tor: the	ertification;	2 Accident investigation inves	ot be 280 Blace	of Injury - At I	home farm st	M 1 [Yes 2 □No	28f. Location (St.	reet and Numbe	er or Rura	l Route Number.
Div	r te c	ertii	4 Homicide determine	buildin	g, etc. (Spec	ify)	noot, ladiory, office		City or Town			
	Hospital of the said of the sa	O		Physician: To the b								
	To the Hosi within 24 ho To the Fun completely f	edical	one)	xaminer: On the bas and manne		nation and/or in	nvestigation, in my c	pinion, death occi	irred at the time, da	ate and place, a	nd due to	the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	· (Pain)-c1: ^	hus	29c. Licens			9d. Date signed	. 1	
•	10		NV Shanibha				on) Do	06374	7	11/14	+ 200	08
2	10		30. Name and address of person v	M.D. 122	1 MERC	ANTILE	LANE LAR	GO, MARY	LAND 207	774		
	Sta Registi		31. Date filed (Month, Day, Year) NOV 1 9 2008	Blance .	gistrar's Sign	parte						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Randolph 7:24PM Claudette No. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** University of maryland, Medical Conto Batumore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 20XF Director 083-30-7028 Aug. Panama Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

ther than "natural", or Items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23e or 28e-f show eny Injury or other traumette event, the Medical Examinar must be notified at Director 1X Yes 2 No MD Prince George's Glen Dale 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10915 Legend Manor Lane 20769 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Teacher Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eric Vincent Mavis Gordon-Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Randolph/Husband 10915 Legend Manor Lane, Glen Dale 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/08 Clinton, MD Resurrection Cemetery 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Rd. Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Breast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and physician al s the burial-t Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Vear 4 Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 1 Natural Certification: Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) # 18734 14, 2008

State Registrar Jia

31. Date filed (Month, Day, Year)

NOV 1 9 2008

Chen

Greene Street, Maryland, Baltimore 21201 32. Registrar's Sign dure

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South

22

			For State Registrar	State of I	Marylar			t of Heal e <i>of Dea</i>		lental Hy	/giene Reg. No.	2008	38570
	Physicia		1. Decedent's Name (First, Middle, Las	NNC	Ro	bins	SON	,		2. Date of Do Month	eath Day	Year 12.200	3. Time of Death 2 7:40 PM
0	/Medic Examin		4a. Facility Name (If not institution, give	street and numb	HOS	pital		Town, or Local	tion of Death		Pri	NCC (reorges
	Funeral Director		•	™ 2 ⊠ F	57	last birthday) Yrs.	Months	Days Ho		8. Date of Bi (Month, D 04/05/	1951	Geoi	pplace (State & Foreign intry) gia
	Maryland a-f show	ctor	10a. State 10b. County Maryland Prince (eorge's		ty, Town or Lorenbel				<u> </u>			10d. Inside City Limits 1 XYes 2 No
	with the	I Director	10e. Street and Number 5923 Cherrywood Te	rrace #	201		10f. Zip	Code 0770			10g. Citiz	en of What Cou	intry?
7/	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Everylaction and the notified at once.	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	ent Ever in U es? No			lent of Hispani ify Cuban, Me	c Origin? (Sp xican, Puerto	ecify Yes or N Rican, etc.)	0- 1-	4. Race - Amer Black, White	
BERY/ 21215-0036	d within 72 h giene. er than "natu , tr	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-40	or 5+)	(Give	kind of wor DO NOT us	,	most of work	ing		d of Business/li	ndustry vernment
n)	uld be filed Aental Hygi rked other tic event, ti	To Be (17. Father's Name (First, Middle, Last) Henry Grady Hopki	ns, Jr.					lother's Name dessa	(First, Middle Clark	, Maiden S	urname)	
(=	1 and 2 should be f Health and Mental I em 27 is marked o' ther traumatic eve		19a. Informant's Name/Relationship (7 Adrian Robinson -	,	loo. F	1319	Iron	Forge	Rd., D	istric	t Hei	Town, State, Z	D 20747
Robi 1 Baltimore,	it. Pages 1 rtment of h rtant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		Place of Disponentery, crem t Linco	oln C	emetery	11/17		Bren	ation - City or T	MD
Ba	permit. Departr Importa any inji		21. Signature of Funeral Service Licens	Mil	le					t Linc , Bren		uneral , MD 2	Home 0772
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each a. <u>Metas</u>	h line.	Breast		, ,	h as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	and l-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq							П	
	cate be physicia the bur	dical		d									
.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birt 4 ☐ Pregnar 9 ☐ Unknow	h 2 ☐ Feta ntattime of o	al death 3 □	Ectopic pi Other <i>(sp</i>		- 4		23	3d. Date of deli Month	very Day Year
rds, P	law requires that the das been signed by the	ed by Pł	Part II. Other significant conditions co	ntributing to deatl	h but not res	ulting in the ur	nderlying ca	ause given in F	art I.				the cause of death? obably 4- ₩ Unknown
Division of Vital Records, P.O.	r: The law re icate has be ; page 2 sho	Completed								24a. Was auto perfo 1 □Yes	psy ormed?	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of
fVit	nysician nis certif director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 X Inpi	atient 2 🗆	ER/Outpatien	nt 3 DO	011		n <i>(Check only</i> me 5 □ Res		□Other (Spec	ify)
ion o	Attending Pt death. ctor: After th y the funeral	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of I (Month,	Injury Day, Year)	28b. Time of Injury	M 2	Bc. Injury at Work? 1 □ Yes		28d. Describe			
Divis	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At ho etc. (Specif	ome, farm, stre	et, factory,	office		28f. Location (City or To	(Street and wn, State)	Number or Rui	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1	rsician: To the be iner: On the basi and manner	s of examina	owledge, death ation and/or inv	n occurred vestigation,	at the time, da in my opinion	te and place, , death occur	and due to the red at the time	cause(s) a , date and p	and manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	Meltz	mi		29c	License numl				signed (Month	-
0	5		30. Name and address of person who c				,			20770	1,0 4 61		, =000
	Stat Registra		31. Date filed (Month, Day, Year) NOV 1 8 2008	32. Regi	istrar's Signa				-, .ID				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 12, Physician Clifford John Rees November 2008 3:45P. ™ /Medical 4a. Facility Name (If not institution, give street and number) Greater Laurel Health and Rehabilitation Ctr. 4c. County of Death 4b. City, Town, or Location of Death Examiner Laurel Prince George's 8. Date of Birth Aug. 15, 1923 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 XM 2□ F United Kingdom 85 036-28-0794 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-4 shown any Injury or other traumatic event, the Medical Event. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Laurel Yes 2 No Maryland Director 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code United States 20708 8610 Contee Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Co. Insurance Investigator 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Langdon Llewellvn Rees 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8610 Contee Road Laurel, Maryland 20708 19a, Informant's Name/Relationship (Type. Print) Shirley A. Rees -wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 11/13/2008 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 Worale 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced Liver Disease Physician years /Medical Due to (or as a consequence of): Examiner Hepatitis B vears Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of]: Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed Hepatitis C years Due to (or as a consequence of): burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 2 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No performed? /es 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4XNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury 5 Pending investigation n 24 hours after death.

le Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

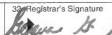
To the l within 2

State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 18 2008 NOV



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jagdish Shesadri, M.D. 14300 Gallant Fox Lane Bowie, Maryland 20715

29c. License number

D53411

29d. Date signed (Month, Day, Year)

November 13, 2008

			For State of Maryland / Dep 1 - State Registrar Ce	artment of Health ar <i>rtificate of Death</i>	nd Mental Hygier Reg.	2000 00=70		
100			1. Decedent's Name (First, Middle, Last)		2. Date of Death	Death 3. Time of Death		
п	Physicia /Medic		Bertha C. Schuler		Nov. 1	Day Year 5 2008 4:27 P M		
	Examin	100	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of I		4c. County of Death		
F			9105 Winding Way	Ellicott Cit		Howard		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		Hrs. 8. Date of Birth Min. (Month, Day, Ye.	ar) 9. Birthplace (State or Foreign Country)		
	Director		215 10 8623 96		Min. (Month, Day, Ye. 03-25-19	12 Maryland		
	and		Usual Residence of Decedent 10a. State 10b. County 10c. Cify, Town or L	ocation		10d. Inside City Limits		
	faryla	P				1		
	the N 28a-i	ect	MD Howard Ellicot	10f. Zip Code	10a.	Citizen of What Country?		
	with a or		9105 Winding Way	21043		United States		
	eath ns 23 mus	era		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,		14. Race - American Indian,		
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	/ Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒No If Yes. Give	If Yes, specify Cuban, Mexican, I 1 ☐ Yes 2 ☑ No Specify:	Puérto Rican, etc.)	Black, White, etc.		
21215-0036	hours tural";	d by	3 ▼Widowed 4 □ Divorced Year or Dates:	edent's Usual Occupation	16h	White Kind of Business/Industry		
7	n 72 n "nat	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of DO NOT use retired)	of working	. Airiu di Business/iliuustiy		
12	withi iene. • than	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Librarian		US Government		
D	i filed I Hyg other ent, i	BeC	17. Father's Name (First, Middle, Last)		s Name (First, Middle, Maid			
ylan	Menta Menta arked artic ev	To B	William Coulling	Ella	Katherine Po	wers		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ing Address (Street and Number Winding Way El				
Baltimore,	Pages 1 annunt of He		1 M Buriai 2 Cremation 3 Chemoval from State	osition (Name of ematory or other place)		Location - City or Town, State		
Iţir	iit. Pa			Park Cemetery		altimore, MD zke's Family FH Inc.		
Ba	permi Depar Impor any ir					ott City, MD 21043		
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as ca	ardiac or respiratory arrest,	Approximate Interval Between Qnset and Death		
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	ereto Tara	eve	Inonthe		
	Examiner		Due to (or as a consequence of):	ebenst doe	ilerso.			
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	uted d ansit	Examiner	Cause (Disease or injury					
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or Vital Records,	8 50	Completed by	Part II. Other significant conditions contributing to death but not resulting in the A **California Contribution** A **California	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
000	aw requir s been si s should t	olete	Appathypridesm. Rinic	useu,	24a. Was an	24b. Were autopsy findings available		
æ	The law ate has b page 2 sh	mo	Fremiad chronicales	e. Lungma	autopsy performed 1 Yes 2 X			
ita		Be C	25. Was case referred to medical	26. Place o	of Death (Check only one)	72100 22100		
>	dir d	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nurs	sing Home 5X Residence	e 6 ☐Other (Specify)		
0 _	ng Ph Iter th neral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at Work?	28d. Describe how in	njury occurred		
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Division	after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)		
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	e Hospital 24 hours a e Funeral l letely filled	Medical	(Check only one) and manner stated.	nvestigation, in my opinion, death	n occurred at the time, date	and place, and due to the cause(s)		
	To the I within 24 To the I complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)		
			14. Robert Birschlaufile	1 4115	-	Nov. 18, 2008		
(r	a		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print) 201 RU-	SSELL AVE	ENUE		
Ú,			14ROBERTBIRSCHBACH, MAD.	641748	RSBURG,	20847		
	Sta Registr		31. Date filed (Month, Day, Year) - 32. Registrar's Signature	Ineste!				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:30 PM VAN -Z4-08 SWAIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLENBURNIE NURSING & REMAR CTR ANNEARUNDE In yrs. last birthday 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Director 11-25-46 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☑ No KEVERNA Director thne Hrunde 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21146 J.S.A. 540 EAST DR Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced DHITE Completed 16a, Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than ATERMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important; If item 27 Is marked o any Injury or other traumatic eve LARENCE C. SWAIN IllIAN м. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1750 MEADOW RD. PASADENA, MD. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State CREMATORY 4 □ Donation 5 □ Other (Specify) 11-26-08 HANDVER, MD, 22. Name and Address of Facility DAUGHERTY FUNERAL HOME uneral Service Licensee Also I MOUNTAID RD. fas about up · 21122 Parf 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on , ach line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a conseque ar /Medical uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9☐Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? Yes 2 No 1□ Yes Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) RELAS Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 2 Accident the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1.2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar 29b. Signature and title of contifier

31. Date filed Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

0

Registrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** STROTHER BEULAH 1:00 PM NOVEMBER 12 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's 5607 Jefferson Heights Drive Capitol Heights If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex Date of Birth (Month, Day, **Funeral** Hours Days 1 □ M 2√E F 1918 13 Prince George's Director Jan 579-32-0408 Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Medical Evanting any other traumatic event, its Medical Evanting any once. 1 X Yes 2 □ No Prince George's Capitol Heights Director Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20743 5607 Jefferson Heights Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Black þ Specify. 3 √Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government 12th Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LAURA E. JACKSON HERBERT S. DUCKETT SR. ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORRAINE J. HILL/DAUGHTER 1120 HOLLYWOOD BLVD HOLLYWOOD, FLA. 33019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 11/18/2008 LANDOVER, MARYLAND 22. Name and Address of Fecility 21. Signature of Funeral Service Ligensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or es a consup Alcheimen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 more Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an this certificate has al director, page 2 autopsy performed? of Vital 1 □Yes 2√□No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier

CR 4
State

NOV 1 9 2008

30 Name and address of person

36 35 32. Registrar's Signature

ho completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death raus **Physician** Day Year arri a.miz Nev 200 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 922 Hastik -ounty Heward Celiemb MD ia ONar If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 🖒 8 Director 1-6-1920 BIG STONE GAP. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar mast be notified at Howar Director 0 1 □ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6413 WINDHARP WAY Funeral 21045 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Š Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: 1945 **BLACK** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) YRS. ASSO. MAIL CARRIER U.S. POST OFFICE permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SCOTT STRAUSS ပ KATE FIELDS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVELYN STRAUSS-WIFE 6413 WINDHARP WAY COLUMBIA, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEM. 11-21-08 BRENTWOOD, MD of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 524 - 8TH ST., N. E. WASH., DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. of enter the mode of dying, such as cardiac or respiratory arm st, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner 20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Dineans Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician the burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) ed by the a 1 □Yes 2 □ No. 9 🗌 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2000 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 051/ 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has 24a. Was an certificate 1 □ Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ Hospital: Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Wher of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the ft 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier ΗD Kery De 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Cedar lane, Celumbia, HD 2044

State Registrar

HULKHERJEE / 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 1 9 2008

RINKLE

Mario Nathanial Shepard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2008 38576

Provided Brunnon Mar 1			Registrar Certificate of D	eath	Reg.					
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The first of the contribution of the contribut	50, te be c sysicia	ledi			-	23d. Date of delivery				
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29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) November 8, 2008 30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signal te	P.C s that gned t	þ	· ·		1 Yes	2 No 3 Probably 4 Unknown				
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) November 8, 2008 30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signal te	ds, equire	eted								
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O.C.M.E. November 8, 2008 30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signal te	To th Within To th comp	ledi	and manner stated.							
30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signal te		2	23b. Signature and tige of certifier							
Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signary te	10		20 News and address of across who completed out to a facility (flow 220)							
	P DOME		Mary G. Ripple MD. Deputy Chief Medical Examiner 111	Penn Street, Baltimore, I	MD 21201					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State of Maryland / Department - State Registrar Certificate		Reg.	7 11 11	8 38577
	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
which is	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, To Laurel Regional Hospital	own, or Location of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 1 M 2 F 75 Yrs.	•	8. Date of Birth (Month, Day, Ye 7/9/1933	ar) 9. Bir	thplace (State or Foreign ountry) ashington, DC
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Prince George's Laurel				10d. Inside City Limits 1 √ Yes 2 □ No
	th with the 23a or 28a unt be not	ral Director	10e. Street and Number 10f. Zip C 9560 Muirkirk Road #102 20	0708	10g.	Citizen of What Co	puntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Modrel Examination in the Incitify at annex.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto No <i>Specify:</i>	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	within 72 ho ene. than "natur ne Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 16a. Decedent's Usual (Give kind of work life. DO NOT use) Flectricis	. Kind of Business			
nd 2	e filed tal Hygi d other event, II	Be Cc	12 Electricia 17. Father's Name (First, Middle, Last)	Priva den Surname)	ice		
Maryland	hould be id Mental marked c matic eve	ဥ	Emil Lee Stone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (S	Loue11 Street and Number or Rui	a Nashwin		Zin Code)
	and 2 sho ealth and n 27 is ma			irk Rd. #102		•	
Baltimore,	Pages 1 ament of He tant: If item		20a. Method of Disposition 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name cemetery, crematory or othe Fort Lincoln Co	emetery 11/2	21/2008 В	Location - City or rentwood	, MD
E Ball	permit. Page Department of Important: If any Injury or once.			Address of Facility For adensburg Ro			Home 20722
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conjequence of):	of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death S DAYS
68760,	rificate be executed g physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			1.	
P.O. Box 68	the death certific by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic preduction of the pregnant at time of death 5 □ Other (special contents).			23d. Date of de Month	livery Day Year
	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cau	se given in Part I.	23e. Did tobaco		o the cause of death? robably 4 ☐ Unknown
Vital Records,	sician: The law re certificate has be- irector, page 2 sho	Completed by	DIFBETTS MEILITUS PAREUMONIA		24a. Was an autopsy performed 1 □Yes 2 🗹	prior to death?	utopsy findings available completion of cause of
Division of Vita	ding Phy After this funeral d	Certification: To Be	25. Was case referred to medical examiner? 1	Other: 4 \(\sum \) Nursing Ho	th (Check only one) ome 5 Pesidence 28d. Describe how in		ecify)
Divis		Certifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, c building, etc. (Specify)	office	28f. Location (Stree City or Town, S		ural Route Number,
)	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1	n my opinion, death occur	rred at the time, date	and place, and due	e to the cause(s)
	viti Non Non	M	If welder my	License number	11	Date signed (Mont	
	(30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Teffrey Wetstone, MD 12201 Plum Orcha) 31. Date filed (MNO Page Year) 2008 31. Registrar's Signature	rd Drive.	Silver Sp	ring, MI	> 20904
	Sta Registr		31. Date filed (MNO Paro Yeij) 2008 37 Registrar's Signature				

DHMH 17 Rev 1/2001

Registrar

NOV 2 0 2008

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Thelma Mae Sims November 14, 2008 12:45 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4h. City Town or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕱 F 58 577-68-0301 Director August 10,1950 Georgia Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits show traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 □ No Maryland Montgomery 28a-f Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 6121 Montrose Road 23a 20852 United States Funeral items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify. þ **Black** Specify: 3 Widowed 4 X Divorced "natural" Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) U.S.Dept. of Housing filed within I Hygiene. than, lementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi. Department of Health and Mental Hygien Important: If item 27 is marked other tha any injury or other traumatic entering once. & Urban Development 12th grade Unit Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jessie Lee Long William Sims ပ 19a. Informant's Name/Relationship (Type. Print) (Daughter), 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Emerson Street, N.W.; Washington, D. C. 20011 Kimberely LaShawn Thompson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 18. 2008 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory, 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Inc. me and Address of Facility 21. Signature of Funeral Service R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of OMINAL INFECTIO Examiner Some flatly list outlitions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine law requires that the death certificate be execute attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) ed by the a 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Vital 1 ☐ Yes 2 ☐ No 1 □Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 University Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 🗆 No 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie completely within 2. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINESH 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State NOV 2 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death STAPLETON Day **Physician** Month FRNEST VOVEMBER 19 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE SOUTHERN MARKLAND HOSPITAL CTR JULIUM GEORGES If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/09/1954 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral 1X** 2 □ F 579-74-5152 54 Director Washington, DC Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City. Town or Location of Health and Mental Hygiene.
item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, it is Nodical Examinar must be notified at 10d. Inside City Limits by Funeral Director MD 1 XYes 2 ☐ No PG Temple HIlls 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4449 23rd Parkway #402 20748 U.S.A. and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2000No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Music Promoter Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Nathaniel Stapleton, Sr. ဥ Majorie Dickens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tracy V. Stapleton - Wife 4449 23rd Parkway #402: Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/19/2008 Harmony Mem. Pk. Landover, Maryland 4 □ Donation / 5 □ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signatur 4594 Beech Road; Temple Hills, MD 23a. Par 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) **Physician** SPIRATORY /Medical Due to (or as a consequence of): Examiner ING CANGER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ANEMIA and Due to (or as a consequence of): Box 68760, Physician/Medical BNORMALITIES ECTROUTE IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 🔲 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Z No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendli within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 💆 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (3) Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 urratts Bal Clinton M HOSHOOL, 31. Date filed (Month, Day, 32. Registrar's State 1 8 2008 Registrar

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene

. Phys	ician dical	Decedent's Name (First, Middle, La LLOYD CHAH		ILL , Sr.	•			2. Date of Month NOVEN	Death Day BER 1,	Year 2008	3. Time of Death 1:30 A
Exan		4a. Facility Name (If not institution, giv					Location of D			y of Death	
Funera Directo		519 Shady Glen 5. Social Security Number 238-48-5490		n yrs. last birthday) Yrs.			Heigh		Princ Pay 1940	9. Birtho	rge's place (State or Foreig th' Carolin
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD PG	10	c. City, Town or Lo		nts				1	I0d. Inside City Limits
th with the 23a or 28 ast be no	Funeral Director	10e. Street and Number 519 Shady Glen Dr	ive		10f. Zip	Code 2074.	3		10g. Citizen of USA	What Cour	ıtry?
ie, intal yialid ZIZIS-0030 stand 2 should be filed within 72 hours after death with the Maryland felaeth and Mental Hydene. It files 71 is marked other than "natural; or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 M Yes 2 □ No. If Yes, Give Year or Dates:	TETNAM	Was Deced If Yes, spec 1 ☐ Yes 2		spanic Origin? n, Mexican, Pi Specify:	(Specify Yes or uerto Rican, etc.)	Bla	ice - Americ ack, White, ify: Bla	etc.
within 72 horane.	Completed	15. Decedent's Et (Specify only highest grave) Elementary/Secondary (0-12)	ducation	16a. Dece (Give life.		k done d e retired	ation furing most of lechnic		16b. Kind of I	Business/In	•
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Hygiene.	To Be Co	17. Father's Name (First, Middle, Last Unknown					18. Mother's		lle, Maiden Surna		,,,,,,
C, INCL YICH TO A Health and Men Pen 27 Is marke ther traumatic		19a. Informant's Name/Relationship (Gloria J. Stanci		1	-	•			nber, City or Town ol Height	, , ,	/
		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State	20b. Place of Dispo cemetery, cre Maryland Ve	matorý or o eteran (Cenet	ery 11/		20c. Location	nam, Ma	
permit. Page Department (Important: if any injury or	ouce.	21. Signature of Funeral Service Lice	Mother	WY 4	4594 Be	ech F	bad; Ten	ple Hills,	eral Serv. Maryland	iœs 20748	}
Physicia /Medica Examine	al	23a. Part1. Inter the disease, or come shock, or hand failure. List only Immediate Cause/(Final disease or condition resulting in death)	plications that caused the one cause on each line. aMETASTAT. Due to (or as a co	IC NON SM					r arrest,		Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue to (or as a co								
eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):							
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	⊒Ectopic pro ⊒ Other <i>(sp</i>					ate of delive	ery Day Year
w requires that the d been signed by the should be detached	Ď		contributing to death but no	ot resulting in the u	inderlying ca	ause give	en in Part I.		_		he cause of death? pably 4 □Unknown
	Completed							pe	as an 24b topsy rformed?	prior to co death?	ppsy findings available mpletion of cause of 2 No
Physician: r this certificaral director, I	å	25. Was case referred to medical examiner?	Hospital:			Δ Othe		Death (Check onl			
Phys	5 :T	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier		8c. Injun	4 🗆 Nursii		esidence 6 🗆 O		у)
ding th.: After	tion:	1 Natural 5 ☐ Pending investigation	(Month, Day Ye	ea <i>r</i>) Injury	м		? Yes 2 □ No		12.7		

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)
NOV 1 4 2008 State Registrar

29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

6 ☐ Could not be

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MD# 33255

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

NOVEMBER 7, 2008

08-08265 Joshua Sands

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia		Registrar		rtificate of	Dealii		Reg.	No. 200	
al Exami		Decedent's Name (First, Middle,Lass JOSHUA DAVI					2. Date of Death Month D November 3	Day Year 5, 2008	3. Time of Death 2100 hrs
		4a. Facility Name (if not institution, giv 3111 Naylor Road	e street and number)	4	b. City, Town, or L Temple Hills	ocation of Death	71010111111111	4c. County of De Prince Geor	
uneral	H	Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth	1	
irector		579-17-3965 ¹ X Usual Residence of Decedent	M 2 F	19 _{Yrs.}	Months Days	Hours Min.	9-22-	8 9 For	Birthplace (State or eign Wash . , DC Country)
' any		10a. State 10b. County	·	, Town or Location					10d. Inside City Limits
Vlaryland 28a-f show d at once.	tor	DC	<u>W</u> a	ashingt					1 X Yes 2 No
and 2 snoot do billed within 72 hours after death with the Maryjand leath and Mental Hygiene. It was a feel and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f sho traminer must be notified at once traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	3 05		10f. Zip Code		10g	. Citizen of What C	ountry?
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alle, or	by F	3 Widowed 4 Divorced	1 Yes 2 No	1	Yes 2 X No	specify:		Specify:B1	ack
nours Fran	ed	15. Decedent's Education (Specify o			s Usual Occupationst of working life. [6b. Kind of Busines	ss/Industry
e. than tadical	Completed	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	Stud	lent		,	Vouth Մ	ransition
be filed within /2 nours ntal Hygiene. rked other than "natur ent, the Medical Exami	Con	17. Father's Name (First, Middle, Last)	Deac		3.Mother's Name	(First, Middle, Ma		Lansicion
Mental F marked event,	Be	Tyrone William					ta San		
and M 7 is m ratic e	7	19a. Informant's Name/Relationship (1 Walletta Sands						er, City or Town, St	
lealth tem 2 traum	s 29	20a. Method of Disposition	20b.	Place of Disposit	ion (Name of ceme			ash., Do	
permit. Pages I and 2 should be file Department of Health and Menial H Important: If item 27 is marked or injury or other traumatic event, the		1 X Burial 2 Cremation 3		crematory or other		11/	13/09 1	Brentwo	ad MD
portai		4 Donation 5 Other Specify 21. Signature of Funeral Service Lips	·			of Facility Aus	tin Ro	ster Fi	ineral Home
	<	Zat		382	1 - 14t	h Stre	et, N.	W., Wasl	nington,DC2
ysician Iedical		23a. Part Enter the disease, or comp	MC floors that caused the death ach line.	h. Do not enter the	e mode of dying, s	uch as cardiac or	respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
aminer	3	mat and a second	Multiple Gunshot Wour Due to (or as a consequence of				_		Death
		Sequentially list conditions, b.	Due to (or as a consequence of	01):					
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	of):					
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executed an and al - transit		d.							
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3 3 G	ın/Medical	IF FEMALE: 23b. Was decedent pregnant in the	AMENDED 23c. If yes, outcome of preg 1 Live birth		al death 3	Ectopic pregnar		23d. Date of delive Month	
ਲ ਲੋਂ	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg Live birth Pregnant at time of de	2 Feta	al death 3	Ectopic pregnar			- 7
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3 3 G	by Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de 9 Unknown	2 Feta	er (Specify)		23e. Did toba	Month	Day Year to the cause of death?
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ystrant: The law requires that the death certificate be estables the experience has been signed by the attending physician director, page 2 should be detached for use as the burial	To Be Completed by	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not determine	23c. If yes, outcome of pred 1 Live birth 4 Pregnant at time of de 9 Unknown contributing to death but not r contributing to death but not r 28a. Date of Injury (Manth Day, Year) Nov 3, 2008	eath 5 Oth resulting in the un ER/Outpatient 28b. Time of In 2052 hrs	26.Place c 3 DDA 0 ury 28c. Injury 1 Ye	f Death (Check o ther Work?	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2 nly one) 2 Home 5 Re 228d. Describe how Subject shot to	Month CCO use contribute 2	Day Year to the cause of death? robably 4 X Unknown autopsy findings available to completion of cause of? Yes 2 No her: Scene
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nopman or returning Friyscrair: The law requires that the beam certificate been 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician rely filled in by the funeral director, page 2 should be detached for use as the burial	Medical Certification: To Be Completed by	25. Was case referred to medical examiner? 1	23c. If yes, outcome of pred 1 Live birth 4 Pregnant at time of de 9 Unknown contributing to death but not re 28a. Date of Injury (Montin Day Year) ion be (Specify) Parking Lo ian: To the basis of examination a and manner stated.	ER/Outpatient 28b. Time of In 2052 hrs 28b. death occurrence 28b.	26. Place of 3 DDA DA	f Death (Check o ther4 Nursing at Work? s 2 No lding, etc.	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2 28d. Describe how Subject shot to a Town, Statist 11 Naylor Roadue to the cause(the time, date an	Month acco use contribute 2 No 3 P 24b. Were prior to death 1 No 1 P esidence 6 Ot Ot winjury occurred by police ad, Temple Hills, s) and manner as s diplace, and due to 199. Date signed (no	to the cause of death? robably 4 X Unknown autopsy findings available to completion of cause of? Yes 2 No No her: Scene Rural Route Number, City Md. tated. the cause(s)

DHMH 17 Rev 1/2001

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Year)

31. Date filed (Month, Day,

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 Edward Evan Scholl November 16, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Months Days 1 ★M 2 ☐ F 76 March 6, 1932 181-22-7877 Usual Residence of Decedent 10c. City, Town or Location 10b. County Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20817 United States 6207 Maiden Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ██No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria 12 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence C. Hummel Harry Mark Scholl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6207 Maiden Lane Bethesda, MD 20817 Norma Jean Scholl (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 20 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 2008 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 2 a. Part 1. E. or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart hailure. List only one cause of each line. Immediate Cause (Final Myocardial Infarction disease or condition resulting in death) Due to (or as a consequence of) Coronary Heart Disease Due to (or as a consequence of): Due to (or as a consequence of)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician /Medical Examiner

attending physician and for use as the burial-tran

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discuss or inju-that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

IF FEMALE:

Approximate Interval Between Onset and Death yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy

Examiner Physician/Medical Be Completed by Certification: To Medical

Edward scholl 11-16-2008 8:16 a.m.

Division of Vital Records, P.O. Box 68760

Part II. Other significant conditions	ontributing to death but not res	23e. Did tobacco us	23e. Did tobacco use contribute to the cause of death?				
Diabetes Mellit	us			1 Yes 2] No 3 🔀 Probably 4 🗌 Unknown		
Chronic Obstruc	tive Pulmonary	Disease		24a. Was an autopsy performed? 1 □ Yes 2 ☑XNo	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ath (Check only one)	☐Other (Specify)					
27. Manner of Death 1 █️Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred		
3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At h	ome, farm, street, facto	28f. Location (Street and	28f. Location (Street and Number or Rural Route Number,			

5 ☐ Other (specify)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certific

D20297

29d. Date signed (Month, Day, Year)

Month

Day

Year

November 17, 2008

8:16 A

10d. Inside City Limits

1 ☐ Yes 2 ☐ XNo

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4701 Willard Avenue Chevy Chase, MD 20815 James Brodsky M.D.

Pregnant at time of death

9 Unknown

State Registrar

31. Date filed (Month, Day, Year) 18 NOV 2008



To the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: After this certifica

filled in by the funeral director,

			For State Registrar		State of Ma	aryland	-	artment of F ctificate of			ental Hy	giene Reg. No	-2.0	108	38	3585
ı	Dharist	g = g	1. Decedent's Name (Fi	rst, Middle, Last)							2. Date of De	eath Da	av	Year	3. Time	of Death
	Physici /Medic		Myrtle Vir	ginia Tl	nomas]	Nov. 1		.008	rear	2:5	5 P ^M
*	Examin		4a. Facility Name (If not	institution, give	street and number)			4b. City, Town, o	r Location	of Death		40	. County	of Death		
*			Baltimore		ton Medic	al Ce	nter	Glen Bur					nne	Arund		
	Funeral		5. Social Security Numb	1 1	7. Ag	e (In yrs. la		If Under 1 Year Months Days	If Unde Hours		8. Date of Bir (Month, Da	rth ay, Year,)	9. Birthp Coun	lace (State try)	or Foreign
	Director		579-28-706	4	IWI ZEST	81	Yrs.		ļ		Feb. 5	, 19	27	Mounds		
	w		Usual Residence of Dec 10a. State 10t	b. County		10c. City,	Town or Lo	cation						1	Od. Inside	City Limits
	sho sho	5		,		Tuch										s 2⊠No
	the N 28a-1	Directo	Maryland Ca	alvert	-	Lust	у	10f. Zip Code			T	10a Ci	tizen of l	What Coun	tru?	
	a or	Ö			T							U.S		TTIAL COURT	uy.	
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	1084 Catt1		Lane 12. Was Decedent	Ever in U.S.	13	20657	lispanic O	Origin? (Spec	cify Yes or No			ce - Americ	an Indian.	
_	ter d	I I	1 Never Married		Armed Forces? 1 ☐ Yes 2 🔯			Was Decedent of H If Yes, specify Cub	an, Mexic	an, Puerto F	Rican, etc.)			ck, White,		
5	irs af	by	3 ☑ Widowed 4 □		If Yes, Give Year or Dates:			1 ☐ Yes 2 ☒ No	Specify	y:			Specif	y: Whi	Lte	
2-003b	2 hou	ē	15.	Decedent's Edu	cation	T I	16a. Dece	dent's Usual Occup	pation			16b. K	Kind of B	usiness/Ind	dustry	
2	nin 7. In "n Medi	Completed	Elementary/Secondar	nly highest grade	College (1-4or 5	5+)	life.	kind of work done DO NOT use retired	during mo d)	ost of workin	ng .					
N	d wit giene grithe the	ĕ	12	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Clerk				Fed	eral	. Gove	rnme	nt
2	e filed al Hygid other vent, tl	Be (17. Father's Name (Firs	t, Middle, Last)					18. Moti	her's Name	(First, Middle	, Maidei	n Surnar	ne)		
yland	should be to and Mental I s marked of umatic ever	2	Raymond C.	Gatts,	Sr.				Lyd	ia 0.	Ander	son				
Mar	2 should be and Mental Is marked raumatic ev	li i	19a. Informant's Name	Relationship (Ty	pe. Print)		19b. Mailir	ng Address (Street	and Num	ber or Rura	l Route Numb	er, City	or Town,	, State, Zip	Code)	
	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Patricia A	. Faris	/ daught			Pennsylva	ınia .							7
e e	of Hi		20a. Method of Dispositi 1 X Burial 2 ☐ Cr		lemoval from State	20b. Pla	ace of Dispo metery, crei	sition (Name of matory or other plac	ce)	Di	ate	20c. L	ocation -	- City or To	wn, State	
Ĕ	Pages ment of I ant: If Ito ury or o		4 □ Donation 5 □		emovar nom otate	Ced	ar Hi	ll Cemete	ry	11/21,	/2008	Sui	t1an	nd, Ma	ry1a	nd
Saltimor	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funera	A .	. 1	, .	22	2. Name and Addre	ss of Fac	ility		47	39 B	altim	ore A	Avenue
_	20 E 20		Clau	dette,	Dascha	anne	3 Ga	isch's Fu	nera	1 Home	e, P.A.	_Hy	atts	ville	, MD	20781
			23a. Part1. Enter the d shock, or heart fai	isease, or compt ilure. List only or	cations that caused ne cause on each li	d the death. ne.	Do not ent	er the mode of dyir	ng, such a	as cardiac o	r respiratory a	arrest,			Approxim Interval B	letween
	Physician		Immediate Cause (Fina disease or condition	ai .	Chronic	Obstr	cuctiv	e Pulmon	arv I	Diseas	ie				Onset an	
ħ.	/Medical		resulting in death)		Due to (or as											
	Examiner		Sequentially list condition	ons.	Smokin										60 Ye	ars
-	pi sit	ine	Sequentially list condition of the cause. Enter Underlyin Cause (Disease or injur	diato g	Due to (or as	8-00 Beque	etide ofjr									
	ecute and -trans	Examine	that initiated events resulting in death) Last	y o	Due to (or as		ongo of):									
Š	oe ex		, receiving in econin, and		Due to (or as	a conseque	erice ory.									
8/00,	ficate be executed physician and sthe burial-transit	dical			l											
_	w requires that the death certific been signed by the attending t should be detached for use as	Me	IF FEMALE:		IO. If use suffeeme	nf prognan								100	1100	
DOX	death certifi e attending id for use as	Physician/Me	23b. Was decedent pre in the past 12 mor	griant	3c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	Ectopic pregnancy	у			i		ate of delive onth	ery Day	Year
o.	the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown)	4☐Pregnant a 9☐Unknown	t time or dea	atn 5L	Other (specify) _								
7.	requires that the een signed by the		Part II. Other significar	nt conditions co	ntributing to death b	ut not resul	ting in the u	nderlying cause giv	en in Parl	t I.	23e. Did	tobacco	use con	tribute to th	ne cause o	f death?
ecoras,	signe d be	b	Congestive					, 5			1 🛛	Yes 2	2□ No	3 ☐ Prob	ably 4[Unknown
Ö	requ	Completed									[04 W		Tau			
ě	e lar has	ldm									24a. Was		240.	Were auto prior to cor death?		
<u></u>											1∐ Yes	2 🛭 N	0	1 ☐ Yes	2 □ No	
N I I	ding Physician: After this certific funeral director,	Be	25. Was case referred to examiner?	<u> </u>	lospital:			ot 3D DOA Oth	205.		(Check only					
o		-T	1 ☐ Yes 2 ☒ No 27. Manner of Death		1 X Inpatie		R/Outpatier 28b. Time o	K OLI BOX	4 🗆 1		ne 5 Res				y)	
	ding J. After fune	io	1 X Natural 5	Pending investigation	(Month, Da		Injury	Wor	rk?]Yes 2[-	.od. Describe	now inju	ary occur	irea		
S	death death ctor: / the	icat	2 ☐ Accident 3 ☐ Suicide 6	☐ Could not be	28e Place of ini	urv - At hon	ne farm str	eet, factory, office		-	8f. Location	(Street a	nd Numi	her or Rura	l Route Ni	ımher
UNISION	or A after Dire	Certification:	4 Homicide	determined	building, et	c. (Specify))	,,,			City or To	wn, Stat	te)	50. 5. 114.4		
	spital ours ours eral filled		29a, Certifier 1X	Certifying Phy	sician: To the best	of my know	/ledge, deat	h occurred at the ti	ime, date	and place, a	and due to the	e cause(s	s) and m	anner as s	tated.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical	(Check only 2 one)	Medical Exami	ner: On the basis of and manner st	of examinati	on and/or in	vestigation, in my	opinion, d	eath occurre	ed at the time	, date ar	nd place,	, and due to	the cause	e(s)
	To the within To the complete	Me	29b. Signature and title	of certifier				29c. Licens	se number	r		29d. Da	ate signe	ed (Month,	Day, Year,)
	->-0		► Guilon	Mas Des	Curiose	- MA			D627	14		1	1/17	/2008	3	
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1			Guillermo						G1e	n Buri	nie, M	D 21	061			
P	Sta	ate	31. Date filed (Month, D	Dav. Year)	a 32. Registr	rar's Signatu	ure				-		_			
	Registr	rar	NOV 1 9	2008	Keen !	K A	met !	•								
DHI	MH 17 Rev 1/2	2001														

DHMH 17 Rev 1/2001

MD Prince Georges Lanham Specify Code December D		1 = State Registrar/Amend#7 PerFHI		2	Cer	tificate of	Death	To 5 : -	Reg. No. 2	UUB	3858
44. Facility Name (from inclusions, give server and number) 45. Social Socially Number 46. Social Socially Number 5. Social Socially Number 6. Social Socially Number 7. Age in you got and social Socially Number 8. Social Socially Number 8. Social Socially Number 1. Social			,					Month	Day	Year	
Doctor's Community Hospital Lanham Lanham Prince Georges 100 10		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location of Death	NOVEM			
Second Security Number Security Number Second Security Number Second Security Number Security Number Second Security Number Second Security Number Security Num		Doctor's Commun	ity Hosp	oital		Lanham					
190. State 100. Colorby 100. Col				e (In yrs. last i 7年 75	birthday) Yrs.			8. Date of B	irth	Birth	place (State or Foreign
Salar File the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Praint in the interval Retween or conditions or conditions or cause on each line. Praint in the interval Retween or conditions or cause on each line. Due to (or as a consequence of):				10c. City. To	own or Loc	cation					10d. Inside City Limits
Sale Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sale Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Circle and Death Conditions. Approximate inte	ito	MD Prince	Georges	Lanha	m						1Y∑Yes 2 □ No
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Sa. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Disease or condition and disease or conditions. Due to (or as a consequence or): Sequentially list conditions, rary, legang to maneciate Cause (Final disease or conditions, rary, legang to maneciate Cause (Final disease or conditions, rary, legang to maneciate Cause (Final disease or conditions, rary, legang to maneciate Cause (Final disease or conditions, rary, legang to maneciate Cause (Final disease) or conditions, rary, legang to maneciate Cause (Final disease) or conditions, rary, legang to maneciate Cause (Final disease) or conditions, rary, legang to maneciate Cause (Final disease) or conditions, rary, legang to maneciate Cause (Final disease) or conditions, rary, legang to maneciate Cause (Final disease) or conditions, rary, legang to maneciate Cause (Final disease) or conditions, rary, legang to maneciate Cause (Final disease) or conditions, rary, legang to maneciate Cause (Final disease) or conditions and maneciate Cause (Final disease) or co	/ Funer		Armed Forces? 1-∑Yes 2 □ N			Yes, specify Cuba —	an, Mexican, Puerto	pecify Yes or N Rican, etc.)	Bi	ack, White,	etc.
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State Stat	. 3	4 ☐ Donation 5 ☐ Other (Specify	()	Beth			y 11/2:	1/2008	Alexan	dria	, VA
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Second Continuous Continu	nysician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea			у				•
Second Process 1 Impatient 2 ER/Outpatient 3 DOA Outlet 4 Nursing Home 5 Residence 6 Other (Specify)	y P			ut not resulting	in the un	derlying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of death?
27. Manner of Death 1	pe:	CONGESTIVE	= HEAT	RT_	19	ICVRE		1 🗆	Yes 2 □ No	3 ☐ Pro	bably 4 🖼 Unknown
Second Process 1 Impatient 2 ER/Outpatient 3 DOA Outlet 4 Nursing Home 5 Residence 6 Other (Specify)	Complet							auto	psy ormed?	prior to co death?	impletion of cause of
Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Be	examiner?	Hospital:	nt OFFER	Outmotions	Oth	or.				
Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier 29a. Certifier 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	_ ⊢	27. Manner of Death	28a. Date of Injur	ry 28b	. Time of	28c. Injur	v at				fy)
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	atio	2 ☐ Accident investigation		y, Year)	injury						
29a. Certifier (Check only one) 29a. Certifier (Scheck only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Sertific		28e. Place of inju	iry - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location City or To	(Street and Nun wn, State)	nber or Run	al Route Number,
		(Check only 2 Medical Exan	niner: On the basis of	f examination a	lge, death and/or inv	occurred at the tir estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time	e cause(s) and i , date and place	manner as : e, and due t	stated. o the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ň	29b. Signature and title of certifier Hull	I)					0	/	Day, Year) 2 00 8
Shobhit, Arora 8118 Good Lyck RoAD LAKHAM, MD 20706				eath (Item 23a	a) (Type, F	Print)	1				

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

			A 171.	artment of Health and Ment	tal Hygier	2000 20507
	5 1 · ·	Ĥ	Decedent's Name (First, Middle, Last)		ate of Death	3. Time of Death
	Physici /Medic		WILLIAM S THOMAS		10nth -14-200	Nay Year 10:50 AM
1	Examin	er	4a. Facility Name (If not institution, give street and number) PRINCE GEORGE S HOSPITAL	4b. City, Town, or Location of Death CHEVERLY		c. County of Death RINCE GEORGE'S
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 87 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Days Hours Min. 11 -	ate of Birth Month, Day, Yea -3-1921	9. Birthplace (State or Foreign Charlotte Hall
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or L	ocation		Maryland 10d. Inside City Limits
	Maryl -f sho	to	MD Prince George's Seat Plea	sant		XXYes 2 □ No
	h the	Director	10e. Street and Number	10f. Zip Code	10g. (Ditizen of What Country?
	23a c		607 64th Place	20743	Uni	ted States
92	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be notified at	/ Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X☐ No	Was Decedent of Hispanic Origin? (Specify Yolf Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 🎛 No Specify:	es or No- , etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Ö	hours ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			
7	in 72 l	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Industry
212	d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)	inist	Gov	vernment
Maryland 21215-0036	et d	To Be C	17. Father's Name (First, Middle, Last) James Thomas	18. Mother's Name (First Mary Green	t, Middle, Maide	en Surname)
ary	2 should I and Men Is marke raumatic		· ·	ng Address (Street and Number or Rural Rout		
	and the least the second secon			4th Place Seat Pleasa		
altimore,	Pa ant: ury		I I I Burial 21-6 remation 3 (I Bemoval from State)	osition (Name of matory or other place) 11-17-20 itan Crematory)08	Location - City or Town, State Exandria Va
Balt	permit. Departn Importa any inju			2. Name and Address of Facility ope Funeral Home 2617	Penn A	Washington DC Ave SE 20020
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or resp	piratory arrest,	Approximate Interval Between
and.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a	- INFAMILION,		Onset and Death
1	Examiner		Due to (ar as a consequence of);	Thry DISPERER AN	1) AK	EMIKAR 2-345
	7 -	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)			0 m/h-240
	ecuted and transi	Examiner	that initiated events	grany mo	STA	en 10mm
8760,	icate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):	TUR HISTORY	Ford	11/4 10m/h-aps
687	ificate g phys	edical	d			
Rox	eath certific attending p	Ž.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3	7 Fatania - ra		23d. Date of delivery
O	the deat by the att	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
Records, P.	es ti	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23	3e. Did tobacco	use contribute to the cause of death?
ဂ္ဂ	s beer shou	Completed	Animin thomas OF	CARA 1 1AC 24	4a. Was an	24b. Were autopsy findings available
ž	The Ia ate ha bage 2	E O	STENTS		autopsy performed?	prior to completion of cause of death?
Vital	cian; ertifica ctor, p	Bec	25. Was case referred to medical examiner?	26. Place of Death (Chec	□Yes 2 □M ck only one)	o 1 □Yes 2 □No
0	Physic this c		1 Yes 2 No Hospital: 1 Inpatient 2 DEA/Outpatie			
ב ס	ding l h. After funer	ţi	27. Mann	f 28c. Injury at Work? M 1 □ Yes 2 □ No	escribe how inju	ury occurred
DIVISION	Atten r deat ector: by the	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str	reet, factory, office 28f. Lo	cation (Street a	and Number or Rural Route Number,
בֿ	tal or rs afte al Dir led in	Cert	4 ☐ Homicide building, etc. (Specify)	Cit	ty or Town, Sta	te)
		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and du vestigation, in my opinion, death occurred at th	ue to the cause(he time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	To the To the Comp	ğ.	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
	12		- Some Areeze M.	25766	1	1/15/08
	DRO		30. Name and address of person who completed cause of death (Item 23a) (Type,		t	1
	Stat		Samuel Alleyne, MD 3001 Hospital Dr C 31 Date filed (Menth Day Year) 32. Red Latra's Section 1	neverly MD 20785		
	Registra		31. Date filed (Manth, Day, Year)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#7perFH11/18/08, BM Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** HENRY W. THOMAS 4:00 AM 10-29-08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital
ocial Security Number 6. Sex Silver Spring Date of Birth Month, Day, Year, 5/30/22 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 √ M 2 □ F New Market,MD 578-20-4847 Director 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1√2 Yes 2 □ No Director D.C. Washington 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3214 Warder Street, N.W. 20010 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No 1942 If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 Never Married 2 Married Specify: 1 ☐ Yes 2 ☐ No Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th College (1-4or 5+) Realty Specialist Dept. of Interior 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be ဥ Edward E. Thomas Margaret A. Fossett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3214 Warder St., N.W., Wash., DC 20010 Una M. Thomas/Wife Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department o Important; If any Injury or once. = 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) College of Med 11/03/08 Washington, DC HU 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austin Royster Funeral Home 3821 - 14th St., N.W., Wash., DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) Cardiopulmonary Arrest /Medical Due to (or as a consequence of): Examiner End Stage Liver Disease Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). Sclerosis Cholangitis burial-trai resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Prostate Cancer for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 □Yes 2 **Jy**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the a certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1

Medical

State

Registrar

31. Date filed (Month, Day, Year) 18 2008 NOV

and title of certifie

SIRAK LEMMA,

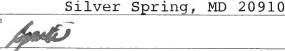
29a. Certifier

29b. Signature



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D-65069

1500 Forest Glen Road

29d. Date signed (Month, Day, Year)

10/29/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 15, **Physician** Richard Arthur Van Horne 10:20 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Althea Woodland Nursing Home 8. Date of Birth (Month, Day, May 27, 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours Min ^{Year)} 1928 152-16-6187 80 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exp. that must be notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9610 Clearview Place 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ ¥ es 2 □ No If Yes, Give Year or Dates: 1951–59 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2x XNo Specify: 2 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Clifton Van Horne Margaret Joyce ဥ 19a. Informant's Name/Relationship *(Type. Print)* Virginia V. Van Horne/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9610 Clearview Place, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Nov. 17, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia 1 week /Medical Due to (or as a consequence of) **Examiner** Multiple Sclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last years Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pivision of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 I Inknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vascular Dementia 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛣 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury TXXNatural 5 Pending I Director: / investigation 1 ☐Yes 2 ☐No 2 Naccident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D01852 November 17, 2008 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queensbury Road, Hyattsville, MD 20781 Paul A. Devore, MD 31. Date filed (Month, Day, Year) Registrar's Signature State 18 2008 NOV Registrar

DHMH 17 Rev 1/2001

Registrar

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			For State Registrar		State 0	ı ıvıaı	ylanu /		rtificate of			nerilai i iy	Reg. N	21115	3 3	3591
	•		Decedent's Name	e (First, Middle,	Last)							2. Date of Do	eath	ay Yea		ne of Death
	Physici /Medic		JANICE	Ĭ		WHIT	TINGT	ON_				NOVEME	BER .	15 2008	9:16	5 A M
Andrew .	Examin		4a. Facility Name (If not institution,	give street and nu	mber)			4b. City, Town, o		on of Death		4	c. County of De		
app m²	-		FREDER: 5. Social Security N		RIAL HOS		AL (In yrs. last	birthdav)	FREDER		der 24 Hrs.	8. Date of Bi	rth	FREDER		tate or Foreign
	Funeral Director		57954-		1□M 2\ F	r. rigo	83	Yrs.	Months Days	Hou	rs Min. De	cember	18, Year	1924	Country) Virgi	nia
	P		Usual Residence of	Decedent 10b. County			10c. City, To	2000 25 1 6	nation						10d Inci	de City Limits
	laryla shov	ō	10a. State MD	,	rles			Pla								Yes 2 No
	the N 28a-i	Director	10e. Street and Nu		TTCB		110	LIA	10f. Zip Code				10g. C	Citizen of What	Country?	
	h with 23a or at be	al Di	717 Cla	arks Run	Road				2	0646				USA		
	ems 2	Funeral	11. Marital Status		12. Was Dece Armed Fo	edent Ev	er in U.S.	13.	Was Decedent of I If Yes, specify Cub	Hispanic an, Mex	Origin? (Spican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ar Black, Wh		an,
36	s afte	by Fu	1 ☐ Never Marr 3 ☑ Widowed	ied 2 ☐ Marrie	d 1 □Yes If Yes, Gi Year or D	ve)		1 ⊡Yes 2 🗖 No	Spe	cify:			Specify:	whit	е
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner mast be notified at	ted t		15. Decedent's	Education	ales.	1	6a. Dece	dent's Usual Occu	pation			16b.	Kind of Busines	s/Industry	
215	thin 73	Completed	(Spec		grade completed) College (I-4or 5+)		life.	kind of work done DO NOT use retire	d)						
21	e filed within al Hygiene. I other than '		1.4	۷				Adm	inistrat	T		tant e (First, Middle	Maide	Census	Burea	u
and	d d d	Be c	17. Father's Name Robert	Lee Hol								Mae Tay		en Surname)		
Maryland	d 2 should be fi th and Mental H 7 is marked ot traumatic evel	၀	19a. Informant's N	ame/Relationshi	p (Type. Print)		1	19b. Maili	ng Address (Stree					or Town, State	, Zip Code)	
ž	l s h a r is		Gloria S	Saloky/D	aughter			717	Clarks R	un R	d. La	Plata.	MD	20646		
ore	es 1 and of Healt if item 2 or other		20a. Method of Dis		B ☐ Removal from	State			osition (Name of matory or other pla		1	Date		Location - City		
Baltimore,	t. Pag tment tant: I		4 ☐ Donation	5 ☐ Other (Spe	ecify)		Trin		Memorial		1		<u> </u>	ldorf,Ma	arylan	d
Bal	permit. Pages 1 and Department of Heatt Important: If item 2: any Injury or other it		21. Signature of Fr	meral Service Li	cepsee	110	1470	2	2. Name and Addr.							
			23a. Part 1. Enter t	the disease, or c	omplications that	aused t	he death. [Do not en	211 St. ter the mode of dy					a,MD 20	Appro	ximate al Between
4	Physician		snock, or nea Immediate Cause disease or condition	(Final	nly one cause on a		MYO	Dat	hy							and Death
1	/Medical Examiner		resulting in death)	4			consequen	ce of):								
п	LXdiiiiici	er	Sequentially list co	enditions,	b	(or as a	consequen	ce of):								
	outed id ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	erlying r injury			,	,								
.09	be executed sician and burial-transit	Exc	resulting in death)	Last	Due to	(or as a	consequen	ce of):								
9289	icate b physic s the bi	dical		,	d											
9 xc	eath certific attending p for use as t	/Me	IF FEMALE: 23b. Was deceder	nt program	23c. If yes, ou									23d. Date of	delivery	
Box	death e atter d for t	iciar	in the past 12	months?	4 Preg	nant at t	E ☐ Fetal de time of deat		☐ Ectopic pregnan☐ Other (specify).					Month	Day	Ye ar
P.0	Physician: The law requires that the death certificate this certificate has been signed by the attending physiral director, page 2 should be detached for use as the	Physician/Medic	9 Unknowr		9 Unki							an Did	Anhana	a von anntrihute	to the cour	e of donth?
	signed be det	ğ	Part II. Other signi	I S and condition		eath but	1		e of Se	ven in P	ап I.			o use contribute 2√√No 3□		4 Unknown
Records,	w requir s been s should	Completed			10 -		***		10			24a. Wa	s an	24b. Were	autopsy find	lings available
Re	: The law cate has l	duo										auto per	opsy formed?	prior death	o completio	n of cause of
Vital	sician: Th certificate rector, pag	BeC	25. Was case refe	rred to medical						26. F	lace of Deal	1 □Yes th (Check only		40 1 1 1	es 2 🗆 N	,
of V	hysic this ce al direc	To E	examiner? 1 ☐ Yes 2 ☐						III 3 LI DOA		Nursing Ho			6 ☐ Other (S	pecify)	
	The The	ion:	27. Manner of Dea 1 ∰Natural	5 Pending		of Injury oth, Day,		Bb. Time of Injury	Wo	uryat ork? ⊡Yes :	2 DNo	28d. Describe	how in	jury occurred		
Division	deat deat ctor: y the	ficat	2 ☐ Accident 3 ☐ Suicide	investiga 6		of Injur	y - At home	e, farm, st	reet, factory, office		2 🗆 100			and Number or	Rural Route	Number,
Ö	al or / s after al Dire	Certification:	4 Homicide		build	ing, etc.	(Specify)					City or To	own, Sta	ate)		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier (Check only		Physician: To the											use(s)
	thin 24	Medical	one) 29b. Signature and	title of certifier	and mar	ner stat	ed.		29c. Licer	ise numb	oer		29d. [Date signed (Mo	onth, Day, Ye	ear)
	5 × 5 0			2 0	Min				D6		4.5					
			30. Name and add	Iress of person w	no completed cau	se of de	ath (Item 23	3a) (Type,	Drint)					- 15-	2	-1702
1	SB 16		Heme	n she	oly 6:	5-0	c Th	ame	us Tol	2111	an b	v,	fr.	ederic	IC 1	10
	Sta Regist		31. Date filed (Mor	NOV 1	7 2008	gistrar	's Signature	× A	puli			,				
.	negist	rell		140 A T	, 2009											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month 2008 Geneva R. Waters 14 8:50 Nov Pм 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) May 10, 1927 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Hours Min. 1 □ M 2 🔀 F Days 215-20-0822 81 MD Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Yes 2□No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10551 Flower St. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2√2 No Specify: Specify: Black 3 X Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Nursing Assistant State Medical Facility 17. Father's Name (First, Middle, Last) Weslev R. Hardv Emma S. Corbin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clemeth Purnell/sister 10551 Flower St., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Hutts Memorial Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/22/2008 Snow Hill, MD Cemetery 22. Name and I dress of Facility 21. Signature of Foreign Source cicens Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seps; S Due to (or as a consequence of): Fibrillation Atrial Sequentially list conditions, land, locally cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Renal Failure

Physician /Medical Examiner Physician/Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examination at the netflied at

Baltimore, Maryland 2121

Pages 1 and 2 should

26110115

DOB

death certificate be executed physician and s the burial-tran Medical Certification: To Be Completed by

P.O.

Hospital or Attending Physician: The law requires that the Vital Records, Division of EVA within 24 hours after death To the Funeral Director: V SSF completely

29b. Signature and title of certifier

JUSON Szymala 31. Date filed (Month, Day, Year) NOV 17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

esulting in death) Last	Due to (or as a conseq	uence of);			
	d				
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 21∰No 9 ∐ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 0	il death 3 ☐ Ectopic pr			23d. Date of delivery Month Day Year
art II. Other significant conditions o	ontributing to death but not res	ulting in the underlying ca	use given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Diabetes				1 🗆 Yes 2	□ No 3 □ Probably 4 Unknown
Coronary a	rtery drseas	e		24a. Was an	24b. Were autopsy findings available
Congestive	heart failvi			autopsy performed? 1 □ Yes 2 2 No	prior to completion of cause of death? 1 □ Yes 2 □ No
5. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)	
1 ☐ Yes 2 2 Ho	Hospital: Inpatient 2 □	ER/Outpatient 3 DO	Other: 4 I Nursing He	ome 5 Residence	6 ☐Other (Specify)
7. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of 28 Injury M	3c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	ry occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory, \dot{y})	office	28f. Location (Street al City or Town, State	nd Number or Rural Route Number, e)
29a. Certifier (Check only one) 12 Certifying Ph 2	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurred a tion and/or investigation,	at the time, date and place in my opinion, death occur	, and due to the cause(s rred at the time, date an	s) and manner as stated. d place, and due to the cause(s)

29c. License number

H64428

29d. Date signed (Month, Day, Year)

11/14/2008

21811

9733 Healthing Drive

Berlin, MD

DHMH 17 Rev 1/2001

State Registrar Atlantic General Hospital

gistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Brozzie Walker 11 12 08 10:07A /Medical 4a. Fadlify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Fort Washington Hospital Ft. Washington Date of Birth (Month, Day, Year)

5/29/1922

9. Birthplace (State or Fore Country)

No Carolina If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours 224-26-9771 86 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Me fical Examiner must be notified at 1 Yes 2 No Director DC Washington the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20019 USA 4318 Polk Street NE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11th College (1-4or 5+) Milk Producers Dairy Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Walker Lizzie Nelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodney Walker/son 2403 Pimpernel Dr. Waldorf, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5 1/22/08 3 ☐Removal from State 5 Other (Specify) Robinson Family Cem Emporia, Virginia 22. Name and Address of Facility 21. Sign al Service LicerSee 420 H St. NE BK Henry Funeral Chapel Wash DC 20002 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Asheroscherok /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ပ 1 Inpatient funeral 27. Manner of Death 1 Hatural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the To the Hospital or Attendent within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Hornicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Hengameh Mesbahi 11711 Livingston Rd Ft. Washington MD 20744 31. Date filed (Month, Day, Year) NOV 1 8 2008 32. Registrar's Signature State Registrar

amend #9 Per FH G887 1/07/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Penusylvania Days Min Months 1 □ M 2 🗓 F 90 159-14-3187 Director Feb 7, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Directo Maryland | Montgomery Takoma Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or my njury or other traumatic event, the Medical Examiner must be 1908. 6509 Westmoreland Avenue 20912 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 X Yes 2 □ No If Yes, Give ↓ Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ĬIWW 1 ☐ Yes 2X No White by Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If item 27 Is marked o Sebastian Medaglia Anna Bonavita 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Wonneberger - Son Fordham Road, College Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery11/25/08 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5/2 disease or condition resulting in death) /Medical Due to fr as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s autopsy performed' this certificate 2x No or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director: Completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue atchimna anna Takoma Park, MD 20912 32. Registrar's Signat 31. Date filed (Month, Day, Year) State NOV 2 0 2008 Registrar

08-08375
Charles Leroy Ware

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	State of Maryland	Department of He	ealth and Menta	l Hygiene

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Physicia	an/	1. Decedent's Name (First, Middle	e,Last)				M I	2. Date of Dea Month		Voor	3. Time of Death
ledical Exami	ner	Charles Le	roy War	e			PAGE 11.11	Novembe	r 7, 2008	Year 3	2241 hrs
		4a. Facility Name (if not institution 5004 Wilkins Drive	n, give street and number	er)		. City, Town, or Lo Temple Hills	ocation of Death			ounty of Death	
								1			
Funeral Director		Social Security Number		Age (In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	8. Date of Bi	rtn (MM/DD/	Foreig	thplace (State or gn
Director		229-80-0552	1 X M 2 F	53	Yrs.	menuis Baye	110010	Dec 9	. 195	4	Virginia
		Usual Residence of Decedent		1							
w an		10a. State 10b. County		10c. City, Town							10d. Inside City Limits
and sho	5	Maryland Prince	George's	Temp	ole Hi	LIIS					1 X Yes 2 No
Mary 28a- d at c	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?
ith the Maryland 23a or 28a-f show any notified at once.		5002 Wilkins D	rive			20748			Unit	ed Sta	tes
with ms 2.	Funeral	11. Marital Status	12. Was Decede			Decedent of Hispa , specify Cuban, I			D- 14.	Race - Amer White, etc.	ican Indian, Black,
death or ite must	Ë	1 Never Married 2 X Ma	1 Yes	2 X No	1103	, specify Guban, i	Mexicall, Fuelto	ixidan, etc.)		wille, etc.	
after al", o	by F		orced If Yes, Give Year or Dates:	21	1 Y	es 2 X No	specify:		Spi	ec <i>ify:</i> B	lack
natur xam		15. Decedent's Education (Spec				Usual Occupation tof working life. I			16b. Kind	of Business	Industry
36 thin 72 h re. than "r	Completed	Elementary/Secondary (0-12)	2 years	or 5+)	_	outer Op		ou,	Go	vernme	nt
within en cr th	Ĕ				o o mi						
Hyg doch		17. Father's Name (First, Middle,				18	8.Mother's Name	,		rname)	
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nat e event, the Medical Exa	Be	Charles Leroy				2.0		nia Tay			
N = = 0	٩	19a. Informant's Name/Relationsh Althea Ware -	, , , , ,	119	_	Address (Street a					
, MD and 2 sho ealth and tem 27 is		20a. Method of Disposition	MILE	20b. Place		on (Name of ceme		Date		ation - City or	
ore Selfin			3 Removal from	State crema	tory or othe	r place)				•	
Lim Pag ment ment		4 Donation 5 Other Sp		Washi	ngton	Nat'1 C	emt No	v 15, 2	08	Suitla	nd, MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1. Signature of Fineral Services	ionsee	SIAN		me and Address o					
		14 SUNKY	(Dres Oll)	1x 1)1 Benni					
Physician /Medical		23a. Part I. Enter the disease, or railyre. List only one cause		ed the death. Do n	ot enter the	mode of dying, si	uch as cardiac o	r respiratory ar	rest, shock,	or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease	a. Gunshot wou								Death
		or condition resulting in death)	Due to (or as a co	nsequence of):							
	ᡖ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):							
	Ē	cause Enter Underlying Cause (Disease or injury that initiated	c.	iooquoiioo eiji							8
, g	Examiner	events resulting in death) Last	Due to (or as a co	nsequence of):			•				
760, frate be executed physician and the burial - transit			٦ ^{d.}								
760, icate be ex physician the burial	n/Medical	UNPENDED	AMENDED								
8760, tifficate be ng physic as the bur	ξ	IF FEMALE: 23b. Was decedent pregnant in th		come of pregnancy			7			Date of deliver	
68 certifi nding se as 1	lä.	past 12 months?	Live Dilti		_	death 3	Ectopic pregna	ncy	Mo	onth	Day Year
Box 68 e death certi the attendin ed for use a	Physicia	1 Yes 2 No 9 Unk			5 Othe	r (Specify)					
P.O. Box 68 s that the death certion and by the attending detached for use a	된	Part II. Other significant conditi	ons contributing to de	eath but not resulting	ng in the und	derlying cause giv	ven in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?
cords, P.O. law requires that the has been signed by 2 should be detach	δ							1 Y	s 2 🗸 N	lo 3 Pro	bably 4 Unknown
ds, equire een si	ted							24a. Was	an I	24b. Were a	utopsy findings available
COT law r has b	휠			· · · - ·				auto perf	psy ormed?	prior to death?	completion of cause of
Re(The icate	Completed							1 🗸 Yes		1 🗸 Y	es 2 No
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of Vital Records, ng Physician: The law require After this certificate has been si nneral director, page 2 should b	힏	1 ✓ Yes 2 No			Outpatient					e 6 🗸 Othe	er: Scene
ision of Vital Rec Attending Physician: The I r death. ector: After this certificate I by the funeral director, page		27. Manner of Death 1 Natural 5 Panel	28a. Date of I (Month, Da Nov 7, 200	njury 28b. X ^{Year)} 221	Time of Inju 1 hrs			28d. Describe Subject sho		occurred	
ttend feath tor:	lä:	- Fend	ing NOV 7, 200	0 221	11115	1 Ye	es 2 🗸 No	,			
Division lal or Attendii rs after death. al Director: A	흹	3 Suicide 6 Could	not be	f Injury - At home, f	arm, street,	factory, office bui					ural Route Number, City
Divi	Certification:	4 V. Homicide	mined (Specify) (Outside home				or Town, 5004 Wilkins	Drive, Te	mple Hills, I	MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge, de	ath occurre	d at the time, date	e and place, and	due to the cau	se(s) and m	nanner as sta	ted.
To the Hos within 24 h To the Fur completely	Medical		miner: On the basis of e and manner state	xamination and/or ed.	ırıvestıgatio			t the time, date			
	Σ	29b. Signature and title of certifie				29c. License	number		29d. Dat	e signed (Mo	onth, Day, Year)
10		' 1/ /(O.C.M	1,E.		Noven	nber 8, 20	08
OCME	ŀ	30. Name and address of person		. ,							
L GOIVIE		Mary G. Ripple MD.	Deputy Chief Me			Penn Street,	Baltimore, M	D 21201			
		31. Date filed (Month, Day, Year) NOV 1 7 2008	32. Regis	trar's Signature	20						
Regist	rar	NOV 1 7 2008	Blocker L	- Aller							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James Walston Henry 2008 November 10. 17:06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner Clinton or 1 Year | If Under 24 Hrs. Southern Maryland Hospital Prince George's 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours 230-62-5733 61 Yrs. Director July 24, 1947 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Mactical Examiner must he matified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Prince George's 1x Yes 2 □ No Camp Springs Directo 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 5156 Clacton Avenue 20746 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. **African** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: American Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Environmental Service Worker Government Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Walston Effie Lee Grant ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bettie J. Lowe - Sister 521 Jordon Pond Lane Bowie, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet's Cemt. Nov 21, 2008 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. E. er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Course (Final disease or condition resulting in death) **Physician** Metabolic /Medical Due to (or as a consequence of): Examiner reval Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disc to (or as a nonsequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendion abusing and Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1∐Yes 2⊠No 1 Annatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) V- Kannan MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURRATTS ROAD, CLINTON - MD SHRI KANNAN 7503 32. Registrar's Signatu 31. Date filed (Month, Day, Year) State NOV 1 7 2008 Registrar

			For State Registrar	State of Marylar		artment of H rtificate of L			ene g. No. 20	3 (385	597
	Physicia	in	1. Decedent's Name (First, Middle, Las James William	-				2. Date of Death		Year	3. Time of I 2:46	
	/Medic Examin	_	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Dea		4c. County of	f Death		
-			2009 Gaither			Temple If Under 1 Year	Hills If Under 24 Hrs		Prince	e Ge	orges	3
	Funeral Director		373-20 0320	7. Age (<i>In yr</i> s 84 84	Yrs.	Months Days	Hours Min		1924	Count SC	ace (State or ry)	
	ow ow		Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo					10	d. Inside Cit	y Limits
	a-fsh	ctor	MD Prince	Georges Tem	ple H	ills					1X Yes	2 No
	h with the 23a or 28 st be no	Funeral Director	10e. Street and Number 2009 Gaither S	St.		10f. Zip Code 20748		10	g. Citizen of Wh	nat Count	ry?	
036	be filed within 72 hours after death with the Maryland trail Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 大了Yes 2 No If Yes, Give 2 / 1 1 Year or Dates.	/43	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☐XNo	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		White, e	etc.	
215-0	filed within 72 ho I Hygiene. other than "natur ent, the Medical I	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired Estate	during most of wo l)	orking	6b. Kind of Bus		•	
⊑	ould be filed w Mental Hygie arked other ti atic event, th	To Be Col	17. Father's Name (First, Middle, Last, James Williams				18. Mother's Na	me (First, Middle, M na Tinsl)	<u> </u>	
	12 sh h and 7 is m traum	-	19a. Informant's Name/Relationship (LaNita William					Gural Route Number, Cemple H				
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1 👺 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of the content of the conten	JHemovai irom State		osition (Name of matory or other place hem Vet		Date 2 18/2008	Chelt	-		D
Baltı	permit. Pag Department Important: I any injury o		21. Sich ature of Funeral Service Lice	nsee	D D	2. Name and Addressunn&Sons	ss of Facility 5 5635	Eads St	. NE W	ash:	ingto	9,DC
٥	Physician /Medical		23a Part1. Enter the disease, or com- shock, or heart failure. List only limediate Cause (Final disease or condition resulting in death)	plications that caused the dear one cause on each line. DEMENTIA a. Due to (or as a conse		ter the mode of dyin	g, such as cardia	ac or respiratory arre	st,		Approximate Interval Bety Onset and D	een Veeth
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	equence of):							
,09/	eath certificate be executed attending physician and for use as the burial-transit	cał Examiner	Cause Disease or injury that initiated events resulting in death) Last	CDue to (or as a conse	equence of):							
	ifficate g physi as the		-	d								
.O. Box	The law requires that the death certifica te has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3[⊒Ectopic pregnancy ⊒ Other (spec <i>ify)</i>	·		23d. Date Mon		-	Year
ds, P.	ires that the de signed by the a	by	Part II. Other significant conditions	contributing to death but not re	esulting in the u	ınderlying cause giv	en in Part I.		acco use contril			
Records,	law require las been sig	Completed						24a. Was ar autops	y pr	ior to cor	osy findings a	available ause of
				1					№ No 11	eath? □Yes	2□ No	
Vital	sician certif rector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ YNo	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	or.	eath (Check only one Home 512 Reside		r (Cnaoife	d.	
o	this ald	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			28d. Describe ho		. , ,	<u>//</u>	
Division or	Attending Physician: or death. ector: After this certification by the funeral director,	Certification:	Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	De 28e Place of Injury - At	home, farm, st	M 1 🗆	Yes 2 □ No	28f. Location (Sti		r or Rura	l Route Num	ber,
á	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a, Certifier 1 🔀 Certifying P	hysician: To the best of my k	nowledge, dea	th occurred at the tir	me, date and pla	ce, and due to the ca	ause(s) and mar	ner as si	ated.	
	he Ho in 24 i	Medical	one)	miner: On the basis of examinand manner stated.	nation and/or ii							
	With com	Σ	29b. Signature and title of certifier	Ullym		D2 372	e number	Į Ž ⁱ	ad. Date signed	668	υay, Year)	
R	8		30. Name and address of person who Martin Weitz	o completed cause of death (ltd 7525 Greenwa	em 23a) (Type a y CT	Drive G	reenbel	Lt,Md.20	770			
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sig	ature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19:00 Nowember Day, 2008ear William C. Washington 4c. County of Death Montgomery 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Takoma Park Washington Adventist Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 1**X** M 2□ F Months Days Hours Washington, D.C June 18, 1934 Usual Residence of Decedent 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits Washington D.C. XXVes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20017 1248 Farragut Place, N.E. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Black 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Mail Carrier 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel C. Hart William C. Washington, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1248 Farragut Place, N.E. Washington, D.C. 19a. Informant's Name/Relationship (Type. Print) 20017 Mrs. Shirley A. Washington (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland 11/14/2008 Ft. Lincoln Cemetery 22. Name and Address of Facility Marshall"s Funeral Home, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 4217 9th Street, N.W. Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last heumeni Due to (or as a consequence of): JE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 📈 б 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of ath 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Livitural 5 Pending investigation 1 ☐ Yes 2 ☐ No

P.O. Box 68760, Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

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Completed

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Physician/Medical

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Certification: To

Medical

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at

nd 2 should be filed within 72 hours after alth and Mental Hygiene. 27 Is marked other than "natural", or ite

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun once.

Physician

/Medical

Examiner

altimore, Maryland 21215-0036

the Maryland

death with

State Registrar

31. Date filed (Month, Day, Year) NOV 1 4 2008

29b. Signature and title of certifier

6 ☐ Could not be



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

AHMIN A

Silver I hu

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

11-10-08 AHMED

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** p^{M} 01, Maurice Bixby Whitlock November 2008 3:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Collingswood Nursing Home Montgomery Rockville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 6. Sex Date of Birth (Month, Day, Year) 1 🙀 M 2 🗆 F Director 183-03-2832 93 July 03, 1915 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinating at 1 Yes 2□No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the "Midcal Example once." 900 Baltimore Road 20851 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:1944–46 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 反 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrocoustic Engineer Walter Reed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Maurice Bixby Whitlock Harriet Hamilton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Whitlock / Spouse 900 Baltimore Road; Rockville, MD 20851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 11/12/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee <u> 1040 Rockville Pike, Rockville, MD 20852</u> complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use only one cause on each line. 23a. Part 1. Enter e diseas shock, or beat failure. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ icate has been siç , page 2 should b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □Yes 2 No 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records, spital or Attending Pilours after death.
neral Director: After t

To the Hospital within 24 hours a

Medical

31. Date filed (Month, Day, Year) State Registrar

3 T Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number 006 2435

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAYED E(SHYYA') icilo Male (

Male Colar 12 10110

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

22. Registrar's Signature

			For State Registrar		State of	iviary			rtment o tificate d		aith and N e <i>ath</i>	nentai Hy	ygiene Reg. No.	3 63 6	8	386	00
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	Physicia /Medic				Duk Yoon							Novembe			80	12:30) pM
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2-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 □ Never Married 2⊠ 3 □ Widowed 4 □ Divo		1 ☐ Yes 2 If Yes, Give Year or Dat	No ⊠			□Yes 2🔼		Specify:			Specify:	vviii.c,	Asian	
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ρ. J	s that ned by deta	by Pr	Part II. Other significant co	ditions	contributing to dea	ath but n	ot resulting in	n the un	derlying caus	e given	in Part i.	23e. Die	d tobacco	use contrib	ute to th	ne cause of d	eath?
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	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 🔀 Cer (Check only 2 🗌 Med one)	ifying Pi ical Exa	nysician: To the miner: On the ba and mann	sis of ex	amination ar	e, death nd/or inv	occurred at t vestigation, in	the time my opir	, date and place nion, death occu	e, and due to thurred at the time	he cause(s ne, date an	s) and man id place, ar	ner as s nd due t	tated. o the cause(s	.)
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	Sta	te.	Robert J. Kre 31. Date filed (Month, Day,		32 Re	gistrar's	Signature			, #3	z/, Olney	, maryla	ina 208	٥٥٧			
	Registr			8 20	08	معلا	K.	A SO	We								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 35M Mary Alexander November 29 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 51. Agnes 5. Social Security Number Hospital 6. Sex saltimore. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗗 219-28-2865 80 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov Baltimore Director 1 ☐ Yes 2 ☐ No Daltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 WSA Funeral items in 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedo... Armed Forces? 1 □Yes 2 □ 1 Yes 2 III If Yes, Give Year or Dates: 1 NeverMarried 2 Married th and Mental Hygiene.
7 is marked other than "natural", or it traumatic event, the "sedical Examin altimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: ģ Specify: BIK 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health NUISING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) hloe Jones Thompson Horace ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🎖 🕯 😼 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau once. Pages 1 and 2 Alexander (Son) 6140 with row Downs S1. Jeffreu las Vages, NV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nation 3 ☐ Removal from State Cenesara Baltimore, mo 12/4/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur∉ of Funeral Service License Balto. Nat'l Gir 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician SPIRATOR minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Fhours YLMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit death certificate be exect Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Atter this certificate has been si funeral director, page 2 should b HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? LUMBAR DISC 24a. Was an autopsy performed 2 🗆 No 241No 1 ☐ Yes 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 **□**1√0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

JEROME

1 31. Date filed (Month, Day, Year)

DEC 0 4

Hexander, Mar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

SNYDER

172264

900 SOUTH CATON AVENUE BALTIMORE MARYLAND 21229
32 Registra's Signature

NOVEMBER 29,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year VERNON. WILLIAM, AGEL 01:20 PM NOV 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine N/A HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth
Julian, Pay, Yell 924 5. Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Maryland **Funeral** Months 216-18-6198 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show Maryland N/A Baltimore Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 513 South Caton Ave. 21229 USA Funeral 12. Was Decedent Ever in U.S.
Apriled Forces?
14 Tyres 2 No 194
If Yes, Give
Year or Dates: 194 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) d other than "natural", or items 11. Marital Status Race - American Indian, Black, White, etc. 1943-1 Never Married 2 Married 1 □Yes 2√2 No Specify 2 1946 Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any injury or other traumatic event, The Med Elementary/Secondary (0-12) College (1-4or 5+) Milkman Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John William Agel Hilda May Sanders ပ္ 19a. Informant's Name/Relationship (Type. Print)
Peggy Lou McComas, daughter Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7875 Leymar Road Glen Burnie, MD. 20a. Method of Disposition

1 Description

1 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Loudon Park Cemetery 12-1-08 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama All brose Fulleral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INFECTION a. URINARY TRACT ~ 4 WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ~ I WEEK DEHYDRATION Sequentially list conditions, Examiner Duri to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ~ 5 DAY S PNEUMONIA burial-tran Due to (or as a consequence of) Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ALZHEIMER DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

requires that the death certificate be executed Records, P.O. Box 68760. Division of Vital Hospital or Attending Physician: death.

72 hours after death

Baltimore, Maryland 21215-0036

attending physician ρ à signed I has page 2 s certificate After n 24 hours after death.

e Funeral Director: A letely filled in by the form within 2 the

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State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier Kuugno Almudo RES - 00 1

29c. License number 29d. Date signed (Month, Day, Year) NOV 27 2,00%

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUCIANA 3001 S HANOUE BALTIMORE AL MEIDA

31. Date filed (Month, Day, Year) DEC 0 4 2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

			. 10	artment of Health and Mental H	ygiene Reg. No. 2008 38603
			Decedent's Name (First, Middle, Last)	2. Date of D	Death 3. Time of Death
	Physici /Medio		ROBERT ANDERSON	Month DECEMB	ER 2 2008 6:16 PM
-	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
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	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217–20–4803 1 1 XM 2 F 82 Yrs.	Months Days Hours Min. 8. Date of E (Month, I Dec.)	9. Birthplace (State or Foreign Country) 28, 1925 MD
			Usual Residence of Decedent	Dec. 2	rib
	how	_	10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	Ba-f s	cto	MD Anne Arundel Glen Burn	ie	1 □Yes 27 No
	vith th	ä	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	sath v	eral	929 Langley Road 11 Marital Status 12. Was Decedent Ever in U.S. 13.	21060	U.S.A.
36	I 2 should be filed within 72 hours after death with the Maryland h and Mental Hyglene. It am Area 23a or 28a-f show Is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examirer must be recitled at	by Funeral Director		Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 ∰No <i>Specify:</i>	14. Race - American Indian, Black, White, etc. Specify: White
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<u>B</u>	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic			ng Address (Street and Number or Rural Route Num Langley Road Glen Burni	
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e E			TEMBURAL 2 LI CIERRALION 3 LI REMOVALITORI STATE	en Mem.Park Dec. 8,	Glen Burnie, MD
Ħ H	p. rmit. Page D. partment o Important: If any Injury or			2. Name and Address of Facility 5, Ng/eto	
Ď	90		Mark A. Varum Mo1357 6		1661
			23a. Part 1. Etter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.		arrest, Approximate Interval Between
· Ne	Physician		Immediate Cause (Final disease or condition 20N GESTIVE HE	ART FAILURE	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):		
		<u>ا</u>	Sequentially list conditions, if any, leading to immediate b. CHRONIC OBST21	UCTIVE PULMONARY	DISCASE
	uted d insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	V DIFFACE	A .
<u>,</u>	an and rial-tra	Еха	resulting in death) Last C. Due to (or as a consequence of):	7 110,130	
8/60	icate be executed physician and s the burial-transit	dical	d		
20	ertifica ing pt e as tt	Med	IF FEMALE:		
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician/Me	23b. Was decedent pregnant in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
7	that t	by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
	requires been sign hould be			1	Yes 2 No 3 Probably 4 Unknown
He He	The law cate has b page 2 sl	Completed		24a. Wa aut per 1	opsy prior to completion of cause of death?
VItal	Physician: this certific ral director, I	Be	25. Was case referred to medical examiner? 1 Types 250 No. Hospital:	26. Place of Death (Check only	
	Phys rthis raldi	ا ا	1 ☐ Yes 2 ☑ No ☐ No	1 3 DOA 4 Nursing Home 5 Re	sidence 6 Other (Specify)
0	th. : Afte	ţi	1 Matural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	f 28c. Injury at Work? 28d. Describe	s now injury occurred
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office 28f. Location City or To	(Street and Number or Rural Route Number, wn, State)
-	spital ours a neral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	h occurred at the time, date and place, and due to the	ne cause(s) and manner as stated
:	ne Hoo n 24 h ie Fur bletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the time	a, date and place, and due to the cause(s)
i	within Comp	M	29b. Signature and title of certifler	29c. License number	29d. Date signed (Month, Day, Year)
	;		Church MD	RES 001	DECEMBER 1 2008
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, CHRISTINE MIN 3001 S HANDVE		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	Registr	ar	DEC 0 4 2008 June 15 April	<i>J</i>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38504 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Rudolph A. Antinozzi 620 P 11-28-2008 /Medical 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Harford Avondell Asst. Living Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-20-1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Days Hours Min. 1 X M 2 □ F Vrs 81 Director 219-22-7348 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2X No Director MD Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code d other than "natural", or items 23a or event, the Medical Examiner must be r USA 21014 128 W. Ring Factory Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ White 3 N Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Industrial Filters Production Planning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event once. Be Martha Carter Anthony Antinozzi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fallston, MD 21047 2711 Fallsbrooke Manor Dr Joseph Antinozzi (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 12-06-2008 St.Patrick's R.C. Cem. McAdoo, PA LFune I Service Les 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signatu 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bilian /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1□ Yes 2 No ospital or Attending Physician: 1 hours after death. uneral Director: After this certificat y filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 TYes 2 🗌 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUNN.

615

32. Registrar's Signature

W. Moc Pha

29c. License number

5555J

Boloir MA

29d. Date signed (Month, Day, Year)

December 1,2008

08-09026 John Abbate Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

John Abbate	1-	For State	State o	of Maryland /	Depart <i>Certi</i> i	ficate of De	aith aire ath	J Mentai	rrygier	Reg.	No.	201	08	3860
Physician		egistrar Decedent's Name	e (First, Middle,Last)					**	Mor	e of Death	av Y	'ear	3. Time o	- 1
Medical Examine	1	John A						i - latina of D	Dec	ember 1	2008	ty of Death		1115
7	4	a. Facility Name (i 2707 Lakela	f not institution, give	street and number)			iy, Iown, or Ilston	Location of D	eau		Harfor	•		
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215-0036 be filed within 7 mind Hygiene riked other than rike other than end, the Medica	Be C	John C	. Abbate						erine					
Me Me	2	19a. Informant's N	Name/Relationship (1 W. Abbat	ype, Print) e (Wife)		19b. Mailing Add	dress (Stre idelit	eet and Numbery Driv	er or Rural I re Fal	1ston	, MD	21047	7	
mD and 2 sho ealth and tem 27 is traumati	+	20a. Method of Di	isposition			Place of Disposition rematory or other p	(Name of c	emetery,	Dat	e	20c. Locat	ion - City	or Town, S	itate
Baltimore, permit Pages 1 ar Department of Hee Important: If ite			X Cremation 3			yview Cre		у	12-06	-2008	Ba1t	imore	e, MD	
Itim iii. Pa artmen ortani		4 Donation 21. Signature of F	5 Other Specify	for		22. Name	and Addre	ss of Facility	Schim	unek	Funer	al Ho	ome o	f BelAi
Ba Perm Imp Imp	İ	111	19/11/			Inc	610	W. Mac	Phail	Rd B	el Ai	r. MI	D 210	14 oximate Interval
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ivisior i or Attence after death Director:	cati	2 Acciden	t Investig	ation Dec 1, 200	08 of Injury - At	0130 hrs home, farm, street,	factory, offi	ce building, et	tc. 28			Number o	r Rural Ro	ute Number, City
Division tal or Attendi rs after death.	Certification:	3 Suicide	determi	ot be	Single Fa					or Town, 3 07 Lakelar	nd Drive, I	Fallston,	MD	
Hospi 44 hou Funer			Certifying Phys Medical Examin				d at the time	e, date and planion, death o	ace, and du	e to the cau ne time, date	se(s) and r	nanner as , and due	stated. to the cau	se(s)
To the within 2	Medical	one) 2	and title of certifier	and manner sta	ted.			cense number			29d. Da	te signed	(Month, D	ay, Year)
	2	290. Signature	and title of certifier	11/			- 1	.C.M.E.			Dece	mber 1,	2008	
7.		Yanu	ed s person w	o completed cause	of death (Its	em 23a)	_							
X			E. Southall, MD		ledical Ex	caminer 111	Penn St	reet, Baltir	nore, MD	21201				
	tat	04 D-1- (114)	Month, Day, Year)		istrar's Signa	ature								
Regis			DEOD	4 2005	80	M A	call s			-	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** VIRGINIA BROWN 5:09 рм 2008 Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson 800 Southerly Road Apt. 1213 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb. 21, 1919 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√√F Months Days Hours Min. Maryland 220-36-5317 89 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I.a Medical Examiner must be notified at Director 1 □ Yes 2√No Maryland Baltimore Towosn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road Apt. 1213 21286 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2XXXVo Specify: ۾ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) University Elementary/Secondary (0-12) College (1-4or 5+) Professor Maryland h and Mental Hygie Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Brown Miller Anne ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s.
Department of Health ar
Important: If item 27 is s.
any Injury or other trau 409 Washington Ave. Towson, Maryland 21204 Fred Traub Esq. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State Loudon Park Cemetery 12-5-08 Baltimore, Maryland 4 Donation 5 Other (Specify) of Funeral S 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or omplications, or heart failure. List only on s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ovarian (ancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 25. Was case referred to medica 1 □Yes 2 No Vital or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No nours after death.

neral Director: / 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide e Funeral [Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D041476 12.01.2008 no ress of person who completed cause of death (Item 23a) (Type, Print) Suite 416, BALTIMORE, MD CHARLES ST 21204

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

08-09015 Troy Davis Brown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 38607

Davis DiDWi		For State	Olato o.	,	Certifica	ate of Death			Reg. No		1. 5. 1. 1. 1.
Physicia		egistrar . Decedent's Name (Fir	rst, Middle,Last)					MAC	ite of Death onth Day	Year	3. Time of Death 2304 hrs
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or items	Funeral	1 Never Married	2 Married	Armed Forces?		If Yes, specif	Cuban, Mexican,	Puerto Rica	n, etc.)	Wille, C	71-011
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21215-0036 Muld be filed within 72 hours after the Multal Hygiene. marked other than "matural", or event, the Medical Examiner.		19a. Informant's Name		pe, Print)		9b. Mailing Address	(Street and Num	nber or Rural		, City or Town,	State, ZIP Code)
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Instit. I file and 23 is marked other than "natural", or items 23a or 28a-f sht on other traumatic event, the Medical Examiner must be notified at once		Lillian	Hall	/ Moth	er 3	3607 TU	usa Re	7. D	altim	ove in	ity or Town, State
alt alt	1	20a. Method of Dispos			orom	e of Disposition (Na atory or other place	me of cemetery,)	Da	ate 20	JC. LOCATION - C	nty or rown, state
Baltimore, permit: Pages 1 at Department of He Important: If ite		1 Burial 2	Cremation 3	Removal from S	tate		eme tery	12-0	6-208	Balt	imore, Mo
ti Pa timen rtant		4 Donation 5 21. Signature of Fune	Other Specify:	see .		22. Name and	Address of Facilit	y Vaus	ANN C.		
Baltimo permit: Pages Department o Important: I	1	1/04/8/2	(0.	A	-	8728	Liber-	ty Re	I. Ran	dails	town, MD 2113
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cords, P.O. Box 68760, aw requires that the death certificate be executed that been signed by the attending physician and the standard for use as the burial - transit	<u> </u>	UNPENDED	a.	AMENDED							
60, ate be ev physiciar	edical			23c. If yes, outo	ome of pregnan	icv .				23d. Date of	delivery
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tal tian: certif	o Be Con			Hospital:	ationt 2 🗸 F	R/Outpatient 3	DDA Other	Nursing	Home 5 F	Residence 6	Other:
Z is sign	al dir	1 ✓ Yes	2 No	28a. Date of		8b. Time of Injury	28c. Injury at Wo	ork? 2	28d. Describe ho	ow injury occurr	red
n of ing Pl			5 Pending	Nov 30, 20		2224 hrs	1 Yes 2	✓ No S	Subject shot		
ior Itemo	the the	2 Accident	Investiga	tion	of Injuny At hom	ne, farm, street, fact	ory, office building,	etc. 2	28f. Location (S	treet and Numb	er or Rural Route Number, Cit
Division of Vital Records, tal or Attending Physician: The law requirers after death.	<u>ا آ</u>	3 Suicide	6 Could no determine	t be			.,,	4	or Town, St 000 Oakford	ate) Avenue, Balti	more, Md.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending providence of the contraction of the content	Certification:	4 V Homicide		144.1.37	_Dcal Street	to the consequence of the	the time date and	nlace and o	tue to the cause	e(s) and manne	r as stated.
e Hos			Certifying Physic	cian: To the best of er:On the basis of	η my κnowledge examination and	, death occurred at d/or investigation, in	my opinion, death	occurred at	the time, date a	and place, and	due to the cause(s)
o the	Complete	3		and manner stat	ed.		29c. License numb			29d. Date sign	ned (Month, Day, Year)
	Ĭ Ž	29b. Signature and	title of certifier	. /	Z		O.C.M.E.			December	1, 2008
U Z		leur	n	2							
3 7		30. Name and addr		o completed cause	of death (Item 2	23a)	reet, Baltimore	MD 212	201		
)		Zabiullah A		sistant Medica			Teel, Dallindle	v, 141∪ ∠ 12			
	Stat	e 31. Date filed (Mon	oth, Day, Year)	2000 200	istrar's Signatur	e Losali	· di				
				27 CH 60	South State						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sr. 2008 Edmond Blusiewicz December Ρ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 7519 Iroquois Avenue Edgemere If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 29,1922 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 219-03-2700 1 XM 2 □ F Maryland 86 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinat nust be notified. Director Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7519 Iroquois Avenue 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No lf Yes, Give Year or Dates: Specify: Specify: White <u>≨</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years Long Shoreman Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Blusiewicz Sr. Sabina Chownowski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nona Blusiewicz wife 7519 Iroquois Avenue, Edgemere, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus Cem. Dundalk, Maryland 5, 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the disease, or mplications that caused the deat one on other the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List, nly one cause on each line. 23a. Part 1. Enter the disease, Immediate Cause (Final **Physician** BLADDER CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) Records, P.O. Box 68760, attending physician The faw requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe HEART FAILURE, GOUT 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? WSUFFICIENCY 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No Division of Vital 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ KÑo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

28a. Date of Injury (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

32. F

05

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

9:25

10d. Inside City Limits

Approximate Interval Between Onset and Death

5 YRS

Day

28d. Describe how injury occurred

YVIEW CIRCLE BATIMORE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Year

1 ☐Yes 2 🛣 No

A

To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After filled in by

funeral

After 1

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

30. Name and

5 Pending

investigation

Could not be determined

HAYASH

2008

04

State

Medical

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

IDEMNS

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

08-08770 Isaiah Benjamin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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29b. Signature and title of certifier 29c. License number O.C.M.E. OCME 29d. Date signed (Month, Day, Year) November 23, 2008 30. Name and address of person who completed cause of death (Item 23a) The address M. King, Is. M.D. Assistant Medical Systems and Address A. Relitime as M.D. 21204	he II in 24 he Fr	ca	(Check only Certifying F													
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State Registrar I neoddre M. King, Jr., M.D. Assistant Medical Examiner 111 Penn Street, Baltimbre, MD 21201 **Registrar** **Registrar**	(5)				_	,	,	444.5		D :::		MD C15	04			
State 31. Date filed (Month, Day, Year) Registrar Registrar Registrar			i neoabre M. King, Jr	, IVID.	19				enn Stre	et, Balt	ımbre,	MD 212	U'I			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 8886 12-11-08 vt 7 per fh State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#8, perDVR, G886, 12/12/08C **pftificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O1 Month 2:20 PM T. Barrett 12 2008 Joseph 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Months Days 1**X** M 2□ F 84 Yrs. N.C. 243-38-5697 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10b County MD N/A Baltimore 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1702 E. 29th Street 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 🗓 No Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Industrial 7th grade Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joe Barrett Lena Wilkes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Barrett-Wife 1702 E. 29th Street Balto, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cem 12-8-2008 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H > Branki Malai 1101 Ε. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Etastatic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for selectione our consequence of a Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA DICE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Physician /Medical Examiner 68760, P.0. Records, Vital 5 Division

attending physician and or use as the burial-tran nis certificate has been signed director, page 2 should be det the Hospital or Attending Physician; The hin 24 hours after death. ithin 24 hours after death.

the Funeral Director: A completely filled in by the fu 0

Physician

/Medical

Examiner

Director

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmer must be notified at once.

Baltimore, Maryland 21215-0036

Registrar

Gormley 31. Date filed (Month, Day, Year) State 2008 DEC 04

29b. Signature and itle of cortifie

(Check only one)

30. Name and address of person who completed cause of death (Hem 28a) (Type, Print) 900 Cata Registrar's Signature Caton

and manner stated.



29d. Date signed (Month, Day, Year)

29c. License number

18587

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3861 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Mortha olmon 4b. City, Town, or Location of Deeth Fecility Name (If not institution, give street and number) 4c. County of Death rederick thempton de Kanor Care If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1□ M 2 F 1192873/ Usual Residence of Decedent 7 Newark, Ny 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Thurmont Frederick 10e. Street and Number 10g. Citizen of What Country? U.S.A. exoctin ternes 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specity: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dusewife 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel Ewing Clarence Stover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12845 Catoctin Furnace Rd., Thurmont, MD 21788 William Bedford/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/2/2008 Hanover, Maryland Anatomy Gifts Registry 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee /522 Connelley Drive, Ste.P, Hanover, MD 210/6 23a. Part1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4N Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 3□ DOA 2 ☐ ER/Outpatient 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Examiner Examiner the attending physician and hed for use as the burlel-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical ate hes been signed by the page 2 should be deteched ģ Completed this certificate hes al or Attending Physician: T s efter death. Il Director: After this certificat ed in by the funeral director, pa Be 2 Certification:

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours efter death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or any Injury or other traumatic event, the Medical Examinat must be a

Physician

/Medical

Baltimore, Maryland 21215-0020

Funeral Director

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Completed

Be

death with the Maryland

28c. Injury at Work? 10 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapher stated. 29c. License number 29d. Date signed (Month, Day, Year)

House Are

D43091

Frederich

12-1-08

State Registrar

Medical

Sacrol 31. Date filed (Month, Day, Year)

DEC 04 2008

Mn Registrar's Signature

TOLL 801

To the Hospital of within 24 hours of To the Funeral D

		For State Registrar	State Of IV	laryland / [•	ificate of		iu iviel		eg. No 2	08	388	512
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Medi xamir		4a. Facility Name (If not institution, giver Frederick Villa)	ve street and number			4b. City, Town, c	or Location of I	Death		4c. County			
neral ector		5. Social Security Number 214-22-4795 6. S	Sex 7. A	ige (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. 1	Date of Birth Menth, Day UI • 11	Year) 1927	9. Birthp Coun Ma	lace (State of try) rylane	or Foreign
		Usual Residence of Decedent 10a. State MD Balti	imore	10c. City, Town	n or Loca	Lanso	lowne				11	0d. Inside Ci	* * 7
or 28a	Director	10e. Street and Number				10f. Zip Code			10	0g. Citizen of	What Coun	try?	
must b	Funeral	159 Clyde Avenu		t Ever in U.S.	21227 S. 13. Was Decedent of Hispanic Origin? (Specify Yes or N				Yes or No-		ted S	tates	
0, 0		If Yes, Give 3 ▼Widowed 4 □ Divorced Year or Dates:			 Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 ∑No Specify: 				in, etc.)		ck, White, e	etc.	
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event,	Be	17. Father's Name (First, Middle, Last					18. Mother's			Maiden Surnan	ne)		
marke	ဥ	Herbert M. Man 19a. Informant's Name/Relationship		19b	. Mailing	Address (Stree			M. Sta		, State, Zip	Code)	
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mpor iny in		21. Signature of Funera Service Lics		mader	22. 1	Name and Addr	ess of Facility	Am	brose	Funera	1 Hom	e, In	c.
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To the Hospital within 24 hours To the Funeral completely filled

3 State Registrar

DHMH 17 Rev 1/2001

Medical

DEC 0 4 2008

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

	1- State Registrar	State of Mary		rtificate of			Reg. No.	8 38613
ian	Decedent's Name (First, Middle, Las	it)				2. Date of Dea Month	ath Day	3. Time of Death
ical		JRNS SR.		4b. City, Town, o	r Location of De	Novembe	er 23 20	008 1:46 A
ner	4a. Facility Name (If not institution, give HARFORD MEMORIAL			ľ				ORD CO
	154-26-7837	7. Age (In	yrs. last birthday, 76 Yrs.	Months Days	If Under 24 H Hours M	Irs. 8. Date of Birt in. (Month, Day APR . 29	y, Year)	9. Birthplace (State or Foreig Country) SOUTH CAROLIN
7	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limit
ctor	MARYLAND HARFOR	RD CO		EDGEWOOD				1 ☐ Yes 2 X N
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	
	858 WEST SPRING	G MEADOW CT. 12. Was Decedent Ever			040	(Specify Yes or No-	U.S.A.	- American Indian.
by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2\times No	an, Mexican, Pu Specify:	(Specify Yes or No- lerto Rican, etc.)		White, etc. BLACK
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Be	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Middle,	Maiden Sumame,)
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	19a. Informant's Name/Relationship (7 Karen Burns-Brando			•		Rural Route Number		od, Md 21040
-	20a. Method of Disposition	2	Ob. Place of Disp			Date		city or Town, State
1	1 Burial 2X Cremation 3 4 Donation 5 Other (Specify		METRO CF			-29-08	BALTIMOR	RE, MARYLAND
	21. Signature of Euneral Service Licen	Søle .	WIN	2. Name and Addre 1 C BROWN 321 S PHI	ss of Facility COMMUNI LADELPH	ITY FUNERA	AL HOME-H ABERDEEN,	HARFORD, P.A., MD 21001
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edical Certification: To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a co b. Due to (or as a co c. Due to (or as a co d.	prisequence of): regnancy Fetal death 3 of death 5 ot resulting in the start 28b. Time of linjury At home, farm, start 12b. Time of linjury y knowledge, dea amination and/or in	DEctopic pregnance Other (specify)	26. Place of the results of the resu	23e. Did to 1	23d. Date Mont beacco use contributed and place of Cother now injury occurrence of the course of the	of delivery h Day Year Description of cause of death? B Probably Unknowner autopsy findings availation to completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of the cause of the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:47P.M. WILLIAM LEONARD BRINN 2008 38 wempe /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Cent Washington ! Flen Burr Hone altimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/23/1947 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** Days 1 M 2 □ F Months Hours 214-48-0404 61 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show sdical Exemirer must be notified at 1 ☐ Yes 2 PNo Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2946 Rose Crown Circle 21122 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Evanural 1 Never Married 2 Married 1 □Yes 2 🗹 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Completed by Specify. Specify: 3 Widowed 4 Divorced 1967 White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Hair Stylist Barber Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Riley Brinn, Jr. Josephine Eleanor Gioiosa မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2946 Rose Crown Circle, Pasadena, MD 21122 Josephine Brinn / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem Grdns 12/01/08 | Davidsonville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, PA Riviera Drive, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau-re on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical r, as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Exami and] Due to (or as a consequence of): Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ◯ No 24a. Was an autopsy performed? Yes 200 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Dipatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ∠ Accident 6 ☐ Could not be ¹3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) ut! 30 GAV 14

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar	State of Ma		d / Depa		of H	ealth ar				08	38615
ı	Physici		1. Decedent's Name (First, Middle, Last) Gloria Bledsoe								Date of Death		Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give st	treet and number)	-		4b. City, 1	Fown, or	Location of			т	nty of Death	333 11
	LAGITATI		Franklin Woods				Ro	seda	ale			Bal	Ltimore	2
	Funeral Director		5. Social Security Number 6. Sex 1 1	7. Age M 2∏ F	(In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, 1-24-1	Year) 931	9. Birthpl Coun	lace (State or Foreign try) MD
	ס		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							0d. Inside City Limits
	d sho	ō	MD Harford			Abingo	lon							1 ☐ Yes 2八 No
	28a-	rec	10e. Street and Number			ADINGC	10f. Zip	Code			10	g. Citizen	of What Coun	try?
	h with	Funeral Director	619 Stone Mill Ct				21	.009				USA		
	deat	ner	11. Marital Status 1	2. Was Decedent E Armed Forces?	ver in U	.S. 13.\	Nas Deced	ent of His	spanic Origin	in? (Specif	y Yes or No- an, etc.)	14. F	Race - Americ Black, White, o	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'ra Midical Examinar must be notified at 2008.	by Fu	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0		1 □ Yes 2		Specify:			1	cify: Whi	
Maryland 21215-0036	72 hou	ted	15. Decedent's Educ			16a. Dece	dent's Usua	Occupa	tion	of working	1	6b. Kind o	f Business/Inc	dustry
2	ithin 7 ne.	Completed	(Specify only highest grade	College (1-4or 5	+)				uring most o	or working				
7	led w lygier her th		17. Father's Name (First, Middle, Last)			Cafet	eria	Work		- 110 /5				o. Schools
and	I be fi	Be									First, Middle, M		iame)	
2	hould id Me mark matic	ဥ	Theodore Desautels 19a. Informant's Name/Relationship (Typ	ne. Print)		19b. Mailin	na Address	(Street a			aBounty loute Number,		wn State Zin	Codel
<u>∞</u>	od 2 s lith an 27 is r trau			son)		1			rd Ci		sedale	-		0000,
Ĉ,	s 1 al f Hee item othe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	e of		Date			on - City or To	wn, State
E	Page nent o int: If		1 XBurial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	11y Hi				1-28-	2008	Balti	more, 1	MD
Baltimore,	ppartn spartn sporte y inju		21. Signature of Funeral Service License		-									of BelAir
	89 5 9		MUL	6		In	ic. 61	O W.	MacP	hail	Rd_Bel	Air,	MD 21	014
	Pnysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	eations that caused e cause on each lin	the deat e.	h. Do not ent	er the mode	of dying	, such as ca	ardiac or re	espiratory arre	st,		Approximate Interval Between Onset and Death
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89	The law requires that the death certificate ate has been signed by the attending physipage 2 should be detached for use as the	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	sc. If yes, outcome of	2 Feta	il death 3□	Ectopic pre						Date of delive	ry Day Year
P.O. Box	the deay y the a iched f	ysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown	time of d	leath 5	Other (spe	ecify)						,
	uires that signed b Id be deta	by	Part II. Other significant conditions cont	tributing to death but		ulting in the u		iuse give	n in Part I.			acco use c		e cause of death?
00	w require s been si should b	lete	Hypertensio								24a. Was an	24		osy findings available
Vital Records,	The lav	Completed	THE TO SEE	/ · · ·							autopsy perform 1 Tes 2	ed?	prior to con death? 1 Yes	npletion of cause of 2 No
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on of	Attending Physician: or death. ector: After this certifici by the funeral director, i	Ilon; To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatien 28a. Date of Injur (Month, Day	у	28b. Time of Injury		Bc. Injury Work	at ANUTS	280	5 Reside 1. Describe ho			')
Division of	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeret Director: After this certificate he completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ry - At h	ome, farm, str	_				Location (Str City or Town		mber or Rura	l Route Number,
	To the Hospitel or A within 24 hours after To the Funeret Direct completely filled in by	edical C	29a. Certifier (Check only one) Check only one) Certifying Physical Cardinal Examin	ician: To the best of er: On the basis of and manner sta	examina	owledge, death	occurred a vestigation,	at the tim in my op	e, date and inion, death	place, and occurred	I due to the ca at the time, da	use(s) and te and plac	manner as sta	ated. the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier				290	License	number		29	d. Date sig	ned (Month, L	Day, Year)
)	· ·			v.	NO	>		1	>53	462		11	28/20	200
	8		30. Name and addless of person who cor	npleted cause of de	eath (Iten	n 23a) (Type,	Print)	0		C 1	0			
			31. Date filed (Month, Day, Year)	ND 78 . Registra	r's Signa	DAKU	2009	20	Ad 1	Olev	Bur	lie	UND.	21061
	Sta Registr		DEC 0 4 2008	18 Mariatia	. o orgina		20							

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BRICKMAN FVE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia Howard **Howard County General Hospital** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F O51 - 210 - 5829 Usual Residence of Decedent Director Apr 22, 1934 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantine must be notified at any injury or other traumatic event, the Medical Evantine rust be notified at any once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** Columbia 1 Yes 2 No MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 10591 Twin Rivers Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Man No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Defense/Aeronautics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Brickman Sylvia Cohen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10591 Twin Rivers Road Columbia, MD 21044 Ms. Barbara Brickman - spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Dec 02, 2008 Glen Burnie, MD Atlantic Crematory, LLC Signature of Furgeral Service Licen 22. Name and Address of Facility luntelle Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusing and eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 400 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Department 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Hely mo 14,00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 03 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Harold Kenneth Clingerman 30 2008 Nov. 9:30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson Baltimore 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. Director 071-42-9462 58 11-1-1950 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Modical Eventian must be notified at 1 □Yes 2 No Director MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 511 Warren Rd. 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces? 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married or, 5-0036 1 ☐ Yes 2 No Specify: ģ Specify: white 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Army Corps Elementary/Secondary (0-12) College (1-4or 5+) Public Affairs Specialist Engineers Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fii and Mental F Clifford Earl Clingerman Else Mathes Hannon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Jason Clingerman/son 18 Placid Woods Ct.Parkville,MD21234 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ⇟ Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State Washington, DC 12-1-08 4 ☐ Donation 5 ☐ Other (Specify) Howard Univ.Hosp 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mo1358 Austin Royster Fun.Hm 3821 14th St. NW Washington, DC20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nonTh disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. 1 □Yes 2 □ No 9 Unknown ruser uns centificate has been signed i funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Medical Certification; To Be Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Vital 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2₽No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending in within 24 hours after death.
To the Funeral Director: After Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number december 1, 2008 205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. fretto. Me Ze Zas bm(6701 V

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

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300

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38618 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death og Year 7750 P M **Physician** *fandoru* cooper Month 1 Z 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Slasons Hospice -Northwest Hospital Baltimore handallstown Date of Birth (Month, Day) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 🗙 F Months 216.58.037 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Even, that he notified at Baltimore Cak 1 ☐ Yes 2 🔭 o Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 Yataruba Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Exercit Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) State of Elementary/Secondary (0-12) College (1-4or 5+) Manager Social Service 12th grade years 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be mes Kobinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Drive 6719 GWYNN Oak MD 21207 DUIS ataruba Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Windsor Mill, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses in c. Greene Funeral SUCS Jaua 23a. Part1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) colon cancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) the 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 1 □ Yes 2 24b. Were autopsy findings available prior to completion of cause of death? nas page 2 s certificate Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) of Place 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury nours after death.

neral Director: A
filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) completely within 2 29b. Signature and the of certified 29c. License number 29d. Date signed (Month, Day, Year) 060680 3 09 person who completed cause of death (Item 23a) (Type, Print)
LINEULUN 35 MUNCT WILL TENTUMN, MO 11136 30. Name and address of MICHEUN

Registrar

State

32 Registrar's Signature

2008

DEC 04

			For State Regist	trar		State of Ma	aryiand		artment of rtificate of	Health and Death	Mental Hy	Glene Reg. No.	2008	38619
					First, Middle, La	st)					2. Date of De	eath Day	Year	3. Time of Death
н	Physici /Medic		Jan	nine A	Ann Clem	ents					Decembe		2008	11:20A ^M
	Examin					e street and number)			4b. City, Town,	or Location of Deat			County of Death	
_/			111	L E. 3	3rd Stre	et			Freder	ick			Frederi	ck
	Funeral		5. Social Se	ecurity Num			e (In yrs. la:		If Under 1 Yea Months Days	If Under 24 Hrs Hours Min.		th av. Year)	9. Birth	nplace (State or Foreign intry)
	Director		001	L-50-3	3624	□M 2 X F	38	Yrs.	Worth 5	7,00.0	04/19/			sachusetts
	p ,		Usual Resid		ecedent 0b. County		10a City	Town or Lo	action					10d. Inside City Limits
	anyla shov	7	10a. State MD		on county Frederic	· l·		deric						1 Yes 2 No
	72 hours after death with the Maryland natural", or items 23a or 28a-f show doal Evan her must be norithed at	Director				.13	1160					40 - 000		**
	ith th	Ë	10e. Street						10f. Zip Code			- 0	zen of What Cou	intry?
	ath v	Funeral			Brd Stre			1		701			S.A.	
	er de	nue	11. Marital		_	12. Was Decedent Armed Forces?		13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)	>- 1	 Race - Amer Black, White 	
36	s afte		_		2 Married	1 □ Yes 2√ I If Yes, Give	No		1 □Yes 2 🙀 N	Specify:			Specify: Whi	te
21215-0036	hour tural	Completed by	3 LJ WIG	dowed 4	-	Year or Dates:		16a Dece	dent's Usual Occ	unation		16h Kir	nd of Business/li	nduetni
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	filed within Hygiene. other than "		17. Father's	s Name (Fil	rst, Middle, Last,)		ALLI	21	18. Mother's Na	me (First, Middle			
an	d be ental ced o	Be C		ert E						Jo Paw	lik			
Z	should and Mer s marke umatic	T ₀			e/Relationship ((Type Print)		19h Maili	na Address (Stre	et and Number or R		er City or	Town State 7	in Code)
Maryland	d 2 s Ith ar 17 is trau				Wood/					nleese Dr				1701
	ges 1 and 2 should be filed within 72 hours after death with the Maryla to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it will die it was not be northed at or other traumatic event, it will be a few or other traumatic event.		20a. Metho				20b. Pla		sition (Name of natory or other p		Date		cation - City or T	
lo I	Pages nent of ant: if ite		1□Bu	uriel 2 📈	Cremation 3 ☐ ☐ Other (Special	Removal from State					/2000	Hano	rrow Ma	wl on d
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any Injury or other tr once.				ral/Service Lice		ALCE		Name and Add	viœs 12/3	/2008 Ardent (ver, Ma	
Ba	permit. Departr Importa any Inju		21. Signati	20	2	1366								MD 21076
			23a Part 1	Enter the	disease or com	plications that caused	the death						anover	Approximate
н			shock	k, or heart f Cause (Fir	ailure. List only	one cause on each li	ne.	-3		-				Interval Between Onset and Death
	Physician /Medical		disease or resulting in	condition	iai	a		(7V)	1 5/10	ot 4	Jouna	d		Scionds
_/	Examiner		3		•	Due to (or as	a conseque	ence of):						
н		-er	Sequential	ly list condi	tions,	b. Due to (or as	a conseque	ence of):						
	nsit A lifed	ij	Sequential if any, lead cause. Ent Cause (Dis	ter Underlyi sease or inj	ing									
	exect n and al-tra	Examiner	that initiate	ed events death) Las	_	C. Due to (or as	a conseque	ence of):						
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89		edical												
Box	eath certific attending p	Z	IF FEMALE	E: decedent pi	regnant	23c. If yes, outcome						2	3d. Date of deli	very
m	death e atte	icia	in the	past 12 mo	onths?	1 ☐ Live birth 4 ☐ Pregnant a			☐ Ectopic pregna ☐ Other (specify)				Month	Day Year
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Ф.	res that signed to be deta	by P	Part II. Oth	er significa	ant conditions	contributing to death b	ut not result	ting in the u	nderlying cause o	jiven in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
of Vital Records,	an sig	d b									1 🗆	Yes 2	No 3□ Pro	obably 4 ☐ Unknown
8	w require s been significants	Completed									24a. Was	an	24b. Were eut	opsy findings available
æ	The law	E I									euto	psy ormed? 2 No	prior to c death?	ompletion of cause of
Ta	Iclan: The certificate ector, pag		25 Was ca	eso referred	I to medical	<u> </u>				OS Place of Do	1 ☐ Yes ath (Check only		1 ∐Yes	2 □ No
5		Be c	examin			Hospital:		B/Outpatio	nt 3 DOA	Ma ar.	Home 5 Res			:£.)
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Division	or Attending Fatter death. Director: After in by the funer.	Certification:	1 ☐ Na: 2 ☐ Acc		5 ☐ Pending investigation	December		Unkno		ork? ⊒Yes 2 X No	Shot	Sel	+ in 7	the head
İSI	or Attendater death Director:	lica	3 ⊠ Sui	icide	6 Could not b	e ORa Place of Ini	ury - At hor	ne, farm, sti	ω_{II}	1 '	28f. Location	Street and	Number or Ru	ral Route Number,
ă	afte Dire	erti	4 □Ho	micide	actorninos	building, et	c. (Specify)	me.			City or To	wn, State	11 East	Route Number,
	spita nours nera nera		29a. Certifi			nysician: To the best	of my know	ledge, deat						
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Chec one)	ck only 2	Medical Exe	miner: On the basis of and manner st		on and/or ir	vestigation, in m	opinion, death occ	urred at the time	, date and	place, and due	to the cause(s)
	To th withir To th	Me	29b. Signat	ture and titl	e of certifier	Λ				nse number			e signed (Month	
	,		1	Wax	1 1KM	hres 1	1 (1)) MI	= D	3719	7	Dec	embe	-3,2008) 21701
	5		30. Name a	and address	s of person who	completed cause of c	leath (Item :	23a) (Type.	Print)	2 (-	P. April C.	,
			Aln	n Ka	brevi	MD DMF	15	Wes	7 7th	Street	Fre	Peri	KMI	10715
	Sta	te	31. Date file				ar's Signatu	ire	,		1 1 6		- LES	
	Registr	ar			EC 04 2	008 1	ice to	K LA	S. S. J.					

DHMH 17 Rev 1/2001

		State of Maryland / Departme 1 - State Registrar Certifica				giene Reg. No. 20	08 38620
Physicia /Medic		1. Decedent's Name (First, Middle, Last) James Michael Davis, Sr.		-	2. Date of De Month Dec.	ath	Year 3: 04 A. M
Examin		Carroll Hospice Dove House	Westm	Location of Death		4c. County Carr	of Death O L L
Funeral Director		5. Social Security Number 2.16-48-1972 6. Sex 7. Age (In yrs. last birthday) Months Usual Residence of Decedent	er 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 10/2	I / 1947	Birthplace (State or Foreign Country)
Maryland a-f show	ctor	10a. State					10d. Inside City Limits 1 □Yes 2♣ No
th with the 23a or 28 ust be not	ral Director	10e. Street and Number 10f. Z	ip Code 21784			10g. Citizen of W	,
36 s after dea ", or items	by Funeral	11. Marital Status 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. If Yes, sp 1 □ Nes 2 □ No If Yes, Give 1967–1972 1 □ Yes		ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)		e - American Indian, k, White, etc. White
id 21215-0036 filed within 72 hours after death with the Maryland Hyglene. Hyglene "natural", or items 23a or 28a-f show ent, the We filed Evan in the rotified at	Completed t	15. Decedent's Education 16a. Decedent's Us	vork done d	during most of wor.	king	16b. Kind of Bu	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. Ith and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinations to this death.	Be	2 Locomotive 17. Father's Name (First, Middle, Last)	ve En	18. Mother's Nam		CSX Maiden Surname	e)
Maryland d 2 should be f th and Mental 7 is marked of traumatic eve	ပ	Roland Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address		and Number or Ru		er, City or Town, S	
Baltimore, Mapermit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other transonce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Nacemetery, crematory or	ame of other place	i	Date	20c. Location - 0	City or Town, State
Baltil permit. F Departm Importar any injur		21. Signature of Funda Service Licensee 22. Name a Burr	and Addres	ss of Facility ueen Fun	eral Hor		matory, P.A. d, MD 21784
Certificate be executed American and India physician and se as the burial-transit	I Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the most shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	ode of dyin	g, such as cardiac	or respiratory at	rrest,	Approximate Interval Between Onset and Death 7,24,05 - 4440
atter for u	Physician/Medical	d	specify)			Mon	
Hecords, P.O. ne law requires that the de has been signed by the ge 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause give	en in Part I.		_	bute to the cause of death? 3 Probably 4 Honknown
The larate has	Completed				24a. Was autop perfor 1 □ Yes	rmed? pr	/ere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No
OT VITAI Physician: T r this certificat ral director, pa	: To Be	25. Was case referred to medical examiner? 1		26. Place of Dea	ome 5 Resid	dence 6 🔼 Othe	r (Specify) Dove House
To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director attential director.	Certification:	1		γαι ? ∕es 2 □ No		Street and Number	er or Rural Route Number,
he Hospita in 24 hours he Funeral pletely filled	edical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death occurred to the basis of examination and/or investigation and manner stated.	d at the tim	ne, date and place pinion, death occu	, and due to the red at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
To t To t	Σ	Robert & Rue Man		8597		17-3	(Month, Day, Year)
Stat	(30) Name and address of person who completed cause of death (Item 23a) (Type, Print) 10) 100	ireo	t West	MILLSTON	6 am	21157
Stat Registra		DEC 0 4 2008 Leave J. Jack					

			_ FOI	d / Department of Health ar	nd Mental Hygie	ne	
			1 - State Registrar	Certificate of Death	Reg	No. 2000	33621
	Physic	ian	Decedent's Name (First, Middle, Last) JUAN LUIS DE	I.GADO	2. Date of Death Month	Day Year	3. ⊈ime of Death I
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of I	NOV. 28	, 2008 4c. County of Deatl	1:13 A "
	LAGIIIII	IGI	STELLA MARIS HOSPICE	TOWSON		BALTIMO	DRE
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 2 5 − 4 0 − 1 7 1 9 6. Sex 6 0	Yrs. If Under 1 Year If Under 24 Months Days Hours	Min. 8. Date of Birth (Month, Day, Ye 8 / 8 / 1 9 4	9. Birtt Cor 18 PUE	hplace (State or Foreign untry) RTO RICO
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location			10d. Inside City Limits
	with the Maryland a or 28a-f show	ţoţ	MD CARROLL W	ESTMINSTER			1 XYes 2 No
	th the	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?
	ath wi		29 C UNION ST.	21157		USA	
E.	ter de	Funeral	11. Marital Status 1. Mas Decedent Ever in U.S. Armed Forces? 1. Never Married 2 Married 1	. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White	
3 a.m	ified within 72 hours after death with the Maryland Hygiene. Whyser than "natural", or items 23a or 28a-f show ont, the Weden Exercity or out to mouth of a show ont, the Weden Exercity or out to mouth of a show ont.	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1XYes 2□No Specify:P	UERTO RICA	N Specify: HIS	SPANIC
1:1	"natural";	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most o life. DO NOT use retired)		b. Kind of Business/I	ndustry
_ 5	La y rail of A 1 2 1 3 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	MECHANIC	A	UTOMOBII	ĿΕ
2008	= 0 E 2 5	Be C	17. Father's Name (First, Middle, Last)	\	Name (First, Middle, Mai		4
7	ages 1 and 2 should be file and 7 should be file and 6 health and Mental Hy F. If frem 27 is marked oth or of other traumatic event	으	JUAN		ARMEN		NOWN
28,	Man 12 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number	·		'i
			MIRIAM NUNEZ - SISTER 20a. Method of Disposition 20b. Pla	29 B, Union St., ace of Disposition (Name of	Date 20	c. Location - City or 1	21157 Town, State
WB.	Pages nent or nrt: If i	1	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	I CARROLL CREMATO	2/2/08 W	INFIELD,	MD
NOVEMBER	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Ocensee	22. Name and Address of Facility	FLETCHER F	UNERAL F	IOME, P.A.
Z	7 go = 8 9		I Len / highly at	254 E. MAIN S'		_	
mieska	-		23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only on the ause on each line. Immediate Cause (Final		irdiac or respiratory arrest	'	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) GASTRIC CANC Due to (or as a consequence)				
	Examiner						
7	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury)	ance of):			
V	icate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a consequence of the consequenc	ence of):			
0260	ate be nysicia he bur	edical	d				
	certificate nding physi		IF FEMALE:		7	100	
2	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal c 4 ☐ Pregnant at time of de	death 3 Ectopic pregnancy		23d. Date of deli Month	very Day Year
0 0	the cather tached	hysi	1 Yes 2 No 4 Pregnant at time of det				
		þ	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.		co use contribute to	the cause of death?
E E	r requi	eted					
JUAN DELGA	The faw ate has boage 2 st	Completed			24a. Was an autopsy performed	prior to c	topsy findings available ompletion of cause of
JUAN	ding Physician: The Information of After this certificate hufuneral director, page	BeC	25. Was case referred to medical	26. Place o	1 ☐ Yes 2▲ f Death (Check only one)	lNo 1∐Yes	2 □No
> 90	his in a	TO E			ing Home 5 🗆 Residenc	e 6X Other (Spec	eify) HOSPICE
	fing P	ion:	1 Natural 5 □ Pending (Month, Day, Year)	28b. Time of lnjury at Work? M 1 □ Yes 2 □ No	28d. Describe how i	njury occurred	
	Attendard death octor:	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home determined building into (Specific)	ne, farm, street, factory, office		et and Number or Ru. State)	ral Route Number,
ë	tal or safter al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	tate)	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: Affer t completely filled in by the funeral	Medical	29a. Certifier (Check only one) X Nurse Practite On the basis of examination one) 2 Description on the basis of examination one one of the basis of examination one of the basis of examination one of the basis of examination one of the basis of examination one of the basis of examination one of the basis of examination one of the basis of examination on the basis of examination of the basis of the	ledge, death occurred at the time, date and on and/or investigation, in my opinion, death	place, and due to the caus occurred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)
			* JANWERKNY	1814979	- 1	1/28/08	
	1		30. Name and address of person who completed cause of death (Item 2		TD4 100 01000	,	
	Sta	ite	31. Date filed (Month, Day, Year) 22. Registrar's Signatu	Y VALLEY RD. TIMONI	UM, MD 2109:	5	
	Registr	rar	DEC 0 4 2008	Marie L.			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 5 hard Maryland Department of Health and Mental Hygiene [] [] []

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					Certifica	te of Death	Reg. No.	
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Dete of Death Month Day	3. Time of Death
	/Medic		W-11- e D. 40				NOV 30	2008 3140 p.m
	Examir	er	4a Fecility Name (If not institution, give str	reet and number)		4b. City, Town, or	Location of Deeth 4c. Cour	nty of Deeth
			Seasons Ho	ospice		Kana	allstown £	altimore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	Yrs. Month	er 1 Year If Under 24 Hrs Days Hours Min		Birthplace (State or Foreign Country)
	Director		Usuel Residence of Decedent				Dec. 28, 1940	South Carolina
	puel send	Ì	10a. Stete 10b. County	10c. City	, Town or Location			10d. Inside City Limits
	Menyler f show	ğ	Md N/A	P	altimo	50		1)∑Yes 2□No
	r 28a-f	2	10e. Street and Number		00171 MC	ip Code	10g. Citizen o	f What Country?
	th with 23e or	Funeral Director	3/22 Forces	+ H:11 D	1 .	21207	11	ICA
	death	9	11. Maritel Status	. Was Decedent Ever in U,S	S. 13. Was Dec	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specify Yes or No- 14. R	ace - American Indian,
0	or its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give				lack, White, etc.
2	ours	2	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	I Tes	2 No Specify:	Spec	"Black
21215-0020	ied within 72 hours efter death with the Meryland Vgjene. Ner than "neture!, or items 23s or 23s-f show Nt. the Medical Examiner must be incitined at	Completed	15. Decedent's Educat (Specify only highest grade c		16a. Decedent's Us	ork done during most of wo	orking 16b. Kind of	Business/Industry
121	within ene. then	흕	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)	1	
	be filed with that Hygiene d other the	S	11	0	Truck	Drive	r Lexa	co Appliances
J.	be fi	æ	17. Fether's Name (First, Middle, Last)	11.		18. Mother's Na	me (First, Middle, Maiden Suma	ime)
2	should be nd Mental merked o	ဥ	Alphonso VVI	Illams,		Addi	e Mae D	IXOn
Maryland	2000	- 1	19a. Init rmant's Name/Relationship (Type)	Print) Wite	196. Mailing Addre	ss (Street and Number of H	Rural Route Number, City or Tow	
	s 1 and f Heeith Item 27 other tr	-	M(S, Juan Ia Joh 20a. Method of Disposition	1206. PL	ace of Disposition (N	TOTEST H	Date 20c. Location	1 to . Md . 21207
o o	8 = 5	-1	1 Burial 2 □ Cremation 3 □ Rem	noval from State 4 CS	emetery, crematory of	other place)	12/6/20 D	14- 111
Baltimore,	nit. Pe artmen ortant: Injury	- 1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	LO	rraine	tark Cem.	reputed Da	iro. Ma.
Ba	Departm Departm Importa eny Inju	- 1	21. Signature of Constant Service Electrises	D W	Jose	oh L. Russ	: Funeral H	ome PiA.
		\dashv	touch of	(Russ	/ 2222	. W. North	Ave. Balto	.Md. 21216
4			23a. Pert / Enter the / sease, or complical shock, or heart fellure. List only one	cause on each line.	. Do not enter the me	ode or dying, such as cardia	ic or respiratory arrest,	Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final					
	Examiner	- 1	disease or condition resulting in death) 6	Pener		Cancer		
		b		Due to (or	es a consequence o):		
	d ensit	Examiner	Sequentially list conditions	Due to (or	es e consequence of)-		
ć	an en riai-tr	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	000.00	os o consequence of	r		
68760,	yslole	edical	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence of);		
	deeth certificate be executed e attending physician and ed for use es the burial-trensit	Med	resulting in Geatily Last					1
Вох	th ce		d					1
	he at	30	Part II. Other significant conditions contrit	buting to death but not resul	Iting in the underlying	cause given in Part I.	23b. Did tobacco use o	contribute to the cause of death?
P.0	that the death cened by the attending deteched for use	Physician					1 ☐ Yes 2 ☑ No	3 Probably 4 Unknown
	res the igned be de	<u>ā</u>						
oro	v requires ti been signe should be	e e					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause
Records,	9 8 0	Completed by						of death?
a F	E # 8						1 Yes 30 No	1 ☐ Yes 2 ☐ No
Vital	Physician: The this certificate ral director, peg	Be	25. Was case referred to medical examiner?	pital:			eath (Check only one)	
ō	Phys this ral di	2	10 162 5 NO	1 Inpatient 2 E	ER/Outpatient 3 [28b. Time of	OOA 4 Nursing I	Home 5 ☐ Residence 6, ☐O 28d. Describe how injury occi	ther (Specify) Hosp-ca
on	ding h. After fune	盲	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	, , , , , , , , , , , , , , , , , , , ,	
Division	deat ctor: y the	를 	3 Suicide 6 Could not be	28e. Place of Injury - At hor	ne, farm, street, facto		28f. Location (Street and Nun	nber or Rural Route Number,
Ö	after din t	Certification:	4 Homicide	building, etc. (Specify))		City or Town, State)	
	splta hours nerel y fille	ig l	29a. Certifier 12 Certifying Physici	an: To the best of my know	riedge, death occurre	d at the time, date and place	e, and due to the cause(s) and r	nanner as stated.
	To the Hospital or Attending Phys within 24 hours attendeath. To the Funerel Director: After this completely filled in by the funeral di	edicai	(Check only 2 Medical Examiner one)	 On the basis of examination and manner stated. 	on and/or investigation	n, in my opinion, death occ	urred at the time, date and place	, and due to the cause(s)
	with To t		29b. Signature and title of certifier		2	c. License number	29d. Date sign	ned (Month, Day, Year)
			ceed de			D 29085	Dec	2 2008
	2		30. Name and eddress of person who comp	pleted cause of death (Item	23a) (Type, Print)		Dec.	
	d		A ((a) J - C L. 31. Date filed (Month, Day, Year)	22 Panistrada Ciarat	310	OLD COL	Int Rasa	21133
	Sta Registra	.6	DEC 0 4 2008	32. Registrar's Signatu	& Basal	9		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 3: 37 p.m. December Frank Edmondson 2008 /Medical 4c. County of Death Name (If not institution, give street and number) Examiner or Location of Death Ignes Health N/A timore 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) **№** M 2 🗆 F 90 Months 218-14-9576 **Director** 8/1/18 VA Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinant must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3911 Stokes Dr 21229 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. African 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Ämerican Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glass House Tanker 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Daniel Edmondson Sallie Henry Venable ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maggir Dutton Green/Friend 726 Lynhurst St., Balt., MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Carmel Cem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/6/08 Balt.,MD 21. Signature of Furieral Service License 22. Name and Address of Facili Mari P. Close F.Svs, PA 5126 Belair Rd, Balt.,MD 21206-5105 23a. Part 1. Enfort the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION 1 hour /Medical Due to (or as a consequence of): Examiner b. ATTHEROSCIENTIC CARDIOVASCULAR DISERSE 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burla Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CARDIOMYOPATHY, CONGESTIVE HEART FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CHRONIC OBSTRUCTIVE PULMONARY DISEASE autopsy perform ATRIAL PIBRILLATION, PNEUMUNIA 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 🔲 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) anna 122648 1 December 2008 a and address of person who completed cause of death (Item 23a) (Type, Print) Jerome I. Swypen 900 SOUTH CATON AYENUE BALTIMORE, MARYLAND 21229 m.0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DEC 04

2008

Edmondson,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day traztiess 9:00AM 22,2008 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Inomhurst If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Manth, Day, 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Months. Days Hours Min 40 Director 03 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, IT. Pedical Examination in the invitive at Baltimore Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Thomhurst 2/207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2. No Specify: ģ Black 3 Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Nathaniel Frazier Tillman tlazel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) homas Mondie Court Baltimore MD Thomhurst 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 80 Woodlawn, MD 21. Signature of Funeral Service License Greene Funeral SICO Vauchn C Road Landa 11 stown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heard failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cokonaky /Medical Due to (or as a conseque he of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760 by the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death ō 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Month Year Day 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♠No cate has I page 2 s autopsy certificate performed 2 No 1 □Yes To the Hospital or Attending Prysrcian, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 TYes 2 □ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DEC 04

			For State Registrar	State of Maryland	/ Depa		lealth and N	Mental Hyg			38625
	Dhuaisi		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	n Day	Year	3. Time of Death
	Physici /Medio		Linda Davis	Fleming				December	,	008	8:00 p.M
423	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death			ty of Death	
4	*		Laurel Regional H	lospital		Laur	e1			ince (George's
	Funeral		5. Social Security Number 6. Sex	T71 =		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 10,	Year)	9. Birthp	place (State or Foreign
	Director		223-34-0932	M 2 X JF 65	Yrs.			Feb.10,	1943		VA
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					0d. Inside City Limits
	laryla sho	ក				odion					1 ☐ Yes 2 No
	the M	ect	MD Anne Arur 10e, Street and Number	idel Sever	n	101 7: 0: 1:		1 4.	0.31	f. 14 f	
	with a or	ä	7882 Bastille Pl.			10f. Zip Code 21144			ng. Citizen o	t what Cour	ntry?
	death with the Maryland	era		2. Was Decedent Ever in U.S.	10.1		lanania Origina /Ca		J.S.A.	ace - Americ	Indian
- 10	ter d	표	11. Marital Status 1 □ Never Married 2 ☑ Married	Armed Forces?	13. 1	f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		ack, White,	
336	ırs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	'	l∐Yes 2.2. No	Specify:		Spec	ify: Bla	ack
ŏ	2 hou	Completed by Funeral Director	15. Decedent's Educ	ation	16a. Deced	lent's Usual Occup	ation		6b. Kind of	Business/Inc	dustry
215	hin 7 e. an "n	ple	(Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	kind of work done o OO NOT use retired	during most of work ()	ing			
21	d wit	Эoп		College (1-4or 5+) 2+	Custo	mer Serv	ice Rep.		Reta	il	
nd	al Hy al Hy I oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	faiden Surna	ame)	
<u>la</u>	uld b Ment arkec	일	Jessie Lewis Davis				Lucille	Johnson			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maricel Examinet must be notified at once.		19a. Informant's Name/Relationship (Typ				and Number or Rur			n, State, Zip	Code)
≥,	and and n 27		Mr. Robert L. Flem	P1. Seve	rn, MD 2	1144					
ore	es 1 of H if iter		20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Re	20b. Plac	e of Disponetery, cren	sition (Name of natory or other plac	Dec.	Date 2	0c. Location	- City or To	wn, State
Ē	Pag ment ant: I ury c		4 □ Donation 5 □ Other (Specify)		n Hil	.1s Cemet	ery 20	08	Amhe	rst, V	7A.
Baltimore,	permit. Depart Import any inj once.		21. Signature of Funeral Service License	e	22	. Name and Addres	ss of Facility Sin	gleton F	emation		
_	20 5 6 3	80 0	Mark a. Va		57 Se	rvices l	2nd Aven	ue SW G1	en Bu	rnie,	MD 21061
	Physician /Medical		23a. Part 1. Exter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	PULMONARY E	MBOLU		g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Examiner			Due to (or as a consequer	nce of):						
		e	Sequentially list conditions, If any, leading to immediate	Due to (or as a consequer	nce of):						
V	uted d ansit	Examiner	Cause (Disease or injury	quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease over injury t initiated events c.							
۰,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burlat-transit	Exa	resulting in death) Last	Due to (or as a consequen	ice of):						· · · · · · · · · · · · · · · · · · ·
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89	rtifica ng ph as th	ledi									
Вох	th cel	Physician/Med	ZOD. Was decedent pregnant	Bc. If yes, outcome of pregnancy 1 \subsection Live birth 2 \subsection Fetal de	y Noth 2	Ectopic pregnancy			23d. D	ate of delive	ery
	dea'	Sici	in the past 12-months? 1 □ Yes 2 🖰 No	4 Pregnant at time of dear		Other (specify)	y		V	lonth	Day Year
P.0	that the dened by the a	h,	9 🗆 Unknown								
	w requires that s been signed b should be deta		Part II. Other significant conditions conf			derlying cause give	en in Part I.	23e. Did tob	acco use co	ntribute to th	ne cause of death?
ord	equir	ed	Arteriosclerot	ic Heart Disea	se			1 □ Ye	s 2 □ No	3☐ Prob	ably 4 🕅 Unknown
Records,	e law r has be e 2 sh	Completed by						24a. Was ar		. Were auto	psy findings available
E	The la	E						autopsy perform 1 □ Yes 2	¥d?	death?	mpletion of cause of
Vital	hysician: Thanis certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deatl			1 🗆 163	2 1410
of V	hysic this ce at dire		1 ☐ Yes 2 KNo	ospital: 1 ☐ Inpatient 2 💢ER	/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing Ho	me 5 ☐ Reside	nce 6 🗆 O	ther (Specif	(v)
0	ding Ph h. After th funeral	Certification: To	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	b. Time of Injury	28c. Injury Work	/ at	28d. Describe hor			
Sio	endil sath. or: A he fu	äţi	2 ☐ Accident investigation			M 1 1	Yes 2□No				
Division	I or Attendi after death. Director: A	≝	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Nun State)	nber or Rura	l Route Number,
O	Ital c Irs af ral Di lled ir			(i			1				<u> </u>
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) 1♠ Certifying Phys 2 ☐ Medical Examin	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and r te and place	manner as s e, and due to	tated. the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier			29c. License		29	d. Date sign	ed (Month,	Day, Year)
			1 home 16.	1 Landly "	2	D22	966		Decemb	er 3,	2008
	in		30. Name and address of person who cor	npleted cause of death (Item 23	Ba) (Type, F	Print)		7300 Va	n Duse	-	
	W		Thomas H. Burguie	res, M.D. Lau	rel R	egional H	Hospital,	Laurel,	MD 2	20707	
	Sta Registra		31. Date filed (Month, Day, Year) DFC. 0 4 2008	3. Registrar's Signature	don	w					

Registrar

DEC 0 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Dav **Physician** Year BETTY JANE FRAZIER DECEMBER 2, 2008 11:18 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner GILCHRIST CENTER
Social Security Number | 16. Sex BALTIMORE 9. Birthplace (State or Foreign If Under 1 Year Of Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ XF Months Days Hours Yrs. Director 215-24-9556 12/14/1927 MARYLAND Usual Residence of Decedent 10a State show 10h County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 【No MD 28a-f BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 1112 HALSTEAD ROAD Funeral 21234 USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ō If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify: ş Specify: 3 □ Widowed 4 □ Divorced "natural" WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry is 1 and 2 should be med with the alth and Mental Hygiene.
Item 27 is marked other than "n". (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BAR TENDER 12TH GRADE LOUNGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ ERNEST DEGRAW EDITH GILBERT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr WILLIAM FRAZIER/SON 9400 ORBITAN COUNT BALTIMORE MD 21234
De of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARK CEMETERY 12/6/2008 BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee M00217 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CVANIAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.0. ed by the a 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3e. Did tobacco use contribute to the cause of death? Records, 2 brollatin 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

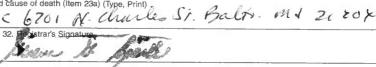
1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate rmed2 2 No Vital 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 □ No sici Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Injury Hospital or Attending 1 Natural 5 Pending investigation November 26, Zook | This Market M 1 E 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) death. n 24 hours after death.
e Funeral Director: A 2 Accident 1 □Yes 2 🗹 No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) FOND, (INKVILLE, MD) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only within 2. the

Registrar

31. Date filed (Month, Day, Year) DEC 0 4

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) .

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29c. License number

29d. Date signed (Month, Day, Year) December 2, 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Gales PM Frances 0210 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner N/A of Baltimore HUS pital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Sex 1 □ M 2 F Funeral 219-70-0827 **50** Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Baltimore 1 Yes 2 No MD **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Be Completed by Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aims Representative Insurance is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gales rances Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Battimore, My 21215

20c. Location - City or Town, State 3408 W. Rogers Ave. Frances Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ţ permit. Page Department of Important: If any injury or once. 5 Burial 2 ☐ Cremation 3 ☐ Removal from State centry 12-1-08 Woodlawn, Mb 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Green Cureral & Signature of Funeral Service Lice see iberty Rd. Randallstown, MD21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** erebral Ida disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Intraccunal Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760, the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ∠No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 November 24, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOS pital 31. Date filed (Month, Day, Year) 32 Registrar's Signati DEC 04 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7.8 per the 886 12-16-08 vt State of Marviand Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** OATHO EUGENE HARCUM SR. 2008 1:50 /Medical November 3.0 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A 2318 MADISON AVENUE BALTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 XXX 2 □ F 87 89 15 19 Director DEC. VIRGINIA 219-03-7591 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director 1xx es 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 2318 MADISON AVENUE 21217 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2KXio If Yes, Give Year or Dates: 42/46 2 Specify Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) varial Mental Hygiene.

127 Is marked other than "r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 10th grade MAINTANCE SUPERVISOR STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JULIUS HARCUM ပ IDA CALLOWAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Sylvia Harcum/Wife 2318 Madison AVe., Baltimore, Item 2 Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If It any Injury or o Burial 2 Cremation 3 Removal from State GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 12-09-08 OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Licen 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nonth disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to infiline dude cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to (or as a consequence of) Examine burial-transit and The law requires that the death certificate be exect Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 2No 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 🗆 Yes 2 🔼 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. within 2 the 29d. Date signed (Month, Day, Year) H 30. Name and address of perso completed cause of death (Item 23a) (Type, Print) N Charles Street, Bathrore MD ZIZIZ 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Jatho Harcum

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** John Patton Hume 1245 AM 27,2008 /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 028-18-4869 12-10-1926 Mass. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examiner must be notified at apprecia Director 1 ☐ Yes 2 ☑ No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 K Moores Mill Rd 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 [V]Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married timore. Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify ş Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Radio Operator Shipping and 2 should be file f Health and Mental Hvo sm 27 is mark-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Hume Frances Kenny ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Adams (Wife) 608 K Moores Mill Rd Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 12-01-2008 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ardiogen. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nyocare Examiner Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Otner (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown tachycovol 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate Division of Vital 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \sum Nursing Home 1 Yes 2 No မ 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ieral Director: filled in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0053568 November 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chasapeake Drive wall ros A 1 HOMPSON Fullston Maryland

State Registrar 31. Date filed (Month, Day,

Year)

WEEMOOD [40054

tome, John

32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Per FH G886 12/09/08 III
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 10 /Medical 4b, City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** Hinore V.A. Medical BALTIMURE CLNTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1**X**M 2□ F 92 Director 217-05-4421 Usual Residence of Decedent 03 MD 10c. City, Town or Location with the Maryland 10a. State 10b. County 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a 21215 U.S.A. **3734 Dolfield Ave** Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hyglene.
The marked other tham "natural", or items 23 ant: If item 27 is marked other tham "natural", or items 23 ury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces?

TOTAL Yes STING
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: Specify: Black þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company Truck Drive 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morris Harris Bernadette Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. Paula Harris-Daughter 3734 Dolfield Ave, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 12/9/08 Owings Mills, Md 22. Name and Address of Facility
March F/H West 2). Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimaore, Md 21215 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, or heart failure. List only one cause on each line. Immeriate Cause (Final CTRICAL Physician disc se or condition resulting in death) /Medical Due to (or as a consequence of): Neymotho Examiner 3 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 2 🗆 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Onknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient မ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 North Greene Street BALL: MURE. MD 21201 SN ASON 31. Date filed (Month, Day, Year) 32 Ragistrar's Signature State DEC 0 4 2008 Registrar

DHMH 17 Rev 1/2001

amend #12

217-05-442

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death ^{Day} 29, **Physician** 2008 6:00 P M November ALBERT T. JONES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X** M 2 □ F MARYLAND 8/10/1933 Director 216-28-2877 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ral", or Items 23a or 28a-f sho 1 ☐Yes 2X No Director MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1716 ABERDEEN ROAD Funeral 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 [X/es 2 □ No If Yes, Give Year or DatesKOREAN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 Divorced WHITE Completed 7 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) YEARS INVENTORY CONTROL MANAGER MARTIN MARIETTA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LUTHER JONES CATHERINE WIESNEIWSKI ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. of Health MARGARET H. JONES/WIFE BALTIMORE, MD 1716 ABERDEEN ROAD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH CEM. 12/3/2008 4 ☐ Donation 5 ☐ Other (Specify) PARKVILLE, MD 21. Signature of Funeral Service 22. Name and Address of Facility MO1139 THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON. MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician Sersis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician sthe burial attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Alzheimer's disease 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 1 □Yes 2 🙀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours aft e Funeral Di letely filled ir 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 hou To the Fune completely fi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0051347 November 30, 2008

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Cynthia Soriano MD 6701 N. Charles St. Baltimore, MD 21204

Registrar
DHMH 17 Rev 1/2001

Months

7. Age (In vrs. last birthday)

10c. City. Town or Location

68

Certificate of Death

Jones

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Days

Randallstown

and manner stated.

2835

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1000G

1. Decedent's Name (First, Middle, Last)

Season's Hospice

10b. County

4a. Facility Name (If not institution, give street and number)

1 □ M 🔏 □ F

Baltimore

Carolyn

5. Social Security Number

216-36-4761

10a State

MD

Physician

/Medical

Examiner

Funeral

Director

Reg. No. 2. Date of Death 3. Time of Death Month Day Year 855A November 2008 4c. County of Death Baltimore Randallstown 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 09 10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. Black, White, etc Specify: Black 16b. Kind of Business/Industry Air Mark 18. Mother's Name (First, Middle, Maiden Surname) 21215 20c. Location - City or Town, State Arbutus, Md 21215 Approximate Interval Between Onset and Death 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 ☐ Yes 2 ☑ No SOASONS HOSPICE Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) NECEMBER 12008 SMITH ATOME SUITE ZOS BALTIMORE MO ZIZOS

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifie

P6borah

31. Date filed (Month, Day,

15

29c. License number

1445931

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 11-25-2008 Frederick G. Knabe 830 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1728 Pine Forest Ct Bel Air Harford 8. Date of Birth (Month, Day, Year) 05-17-1939 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1**∑** M 2□ F Months Days Hours 69 Director 213-36-9808 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exyritor must be multified at 1 ☐ Yes 2 No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1728 Pine Forest Ct Funeral 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian. 1 XiYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plant Manager Manufacturing Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick O. Knabe Lilly Bollinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Knabe (Wife) 1728 Pine Forest Ct Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley 12-01-2008 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licengee Inc. 610 W. MacPhail Rd Bel Air, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Betw Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2 □No signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 🗌 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to examiner? Be 26. Place of Death (Check only Hospital: Other: 4 \sum Nursing Home /2 No Certification: To 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Mann of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 Accident Director: Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral [29a. Certifier ⚠️Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signatu nd address of person who completed cause of death (Item 23a) (Type, Print) Va 31. Date filed (Month, Day, 32. Registrar's Signature State 0 2008 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOSEPHINE A. KUCHTA DECEMBER 2, 2008 6:15 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS NURSING HOME TIMONIUM BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🛛 F Director 216-14-7369 84 12/6/1923 MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Directo MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1631 HARDWICK ROAD or items 23a 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Yes 2 If Yes, Give Year or Dates. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 TNo à Specify 3 Widowed 4 Divorced "natural", WHITE Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be JOHN KERNER မ ANNA MIDDENDORF 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 FRANCIS W. KUCHTA/HUSBAND 1631 HARDWICK ROAD TOWSON. 21286 Saltimore. Department of Heal 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY MEM. 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or GARDENS 12/5/2008 COCKEYSVILLE, MD 21. Signature of Funeral Service Licensee MO0217 any ir THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON. MD 23a. * Int1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) 2008 for use as the burial-transi the attending physician and Due to (or as a consequence of) 68760, requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à Vital Records, Completed 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an autopsy perform 1 ☐ Yes 2 🗀 No 1 ☐ Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA 1 | Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To Division of After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation s after death filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

X NURSE PRACTETTIBLES. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 9 certifie 29c. License number 98

Registrar DHMH 17 Rev 1/2001

State

12

30. Name and address 6

JACKIĔ

31. Date filed (Month,

JONES,

Year)

CRNP

2008

DECEMBER

JOSEPHINE

DULANEY VALLEY ROAD

TIMONIUM, MD 21093

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

23,00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 28 M ICHAEL 2008 7:55 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) 08/18/1943 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1**™**M 2□F Months Hours 439-56-0679 65 Louisiana Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21061 U.S.A. 310 Congressional Court 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 🙀 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)

Aerospace

Ardent Cremation Services

20c. Location - City or Town, State

Hanover, Maryland

18. Mother's Name (First, Middle, Maiden Surname)

Cecile Walker

666 39th St. #21, Brooklyn, NY

Ardent Cremation Service 12/4/2008

22. Name and Address of Facility

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

7522 Connelley Dr., Ste.N. Hanover, MD

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. Physician /Medical **Examiner**

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

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Adrienne Landry/Daughter

DEC 04

2008

1 ☐ Burial 2 【Cremation 3 ☐ Removal from State

Ira Landry

20a. Method of Disposition

Directo

Funeral

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Be Completed

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Funeral

Director

or Attending Physician: The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial.tranci this within 24 hours after death.

To the Funeral Director: filled in by To the Hospital

Division or Vital Records, P.O. Box 68760,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant et time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and time of pertification D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLEN BURNIE. KASAMON, MOSPITAL DRIVE 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Engineer

Place of Disposition (Name of cemetery, crematory or other place)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (1) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 129/2008 4:00 Рм Eileen Ruth Leake 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 3/27/1943 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Yrs 65 215-40-5582 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4819 Buffalo Rd. 21771 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status 1 ∐Yes 2 ₹ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2₺ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Call Center Tevis Oil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna A. McCulley Gilbert Douglas Bergman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4819 Buffalo Rd., Mt. Airy, MD 21771 Richard Leake/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State DBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Ridge Cemetery 12/6/08 Winfield, MD 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility. Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Par 1. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Minute Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☑ No 1 ☐Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

10a. State

MD

Director

Funeral

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, Ir. Medical Evaniment must be mailed at alone.

Baltimore, Maryland 21215-0036

Examiner and Physician/Medical <u>ک</u>

Box 68760,

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Division of Vital Records,

e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been also been als completely filled in by

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in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 ⊒ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ersons, wa 29 egistrar's Signature

State Registrar

Medical

within 2 To the I

		T- State of Mar Registrar		partment of Healt Pertificate of Dea			ene g. No. 2 A A A	30637
Dhyai	nio n	Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
Physic /Med	ical	Joseph R. Lawren	nce	The Control of Control		Nov. 2	29, 2008	8:10 A M
Exam	iner	4a. Facility Name (If not institution, give street and number) Southern Maryland Hosp	pital	4b. City, Town, or Locat			4c. County of Deat P.G.	tn
Funera		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthda)			8. Date of Birth (Month, Day,	Year) 9. Birt	thplace (State or Foreign ountry)
Directo		Usual Residence of Decedent	115.			9-2-3	31 <u>1</u>	V.C.
aryiano Show	_		10c. City, Town or L Suitl					10d. Inside City Limits Yes 2 No
the Ma 28a-f	Director	MD. P.G.	Sulti	10f. Zip Code	<u>.</u>	10	g. Citizen of What Co	
th with	a Di			20746			U.S.A.	•
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highly or other traumatic event, the Medical Examination and more any mark to a confined at the most of the confined at the c	by Funeral	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	er in U.S. 13	. Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 【※No Spe		cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B1	erican Indian, e, etc. Lack
15-0	letec	15. Decedent's Education (Specify only highest grade completed)	(Giv	redent's Usual Occupation re kind of work done during in DO NOT use retired)	most of workin	g 1	6b. Kind of Business/	Industry
212 3 withir giene. Ir than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	1	o Mechanic	:	E	Dept. of	Tran.
be filed that Hyging of the event,	Be	17. Father's Name (First, Middle, Last)				(First, Middle, M	· ·	_
should Mer marke	ြင	Alexander Lawrence 19a. Informant's Name/Relationship (Type. Print)	19h Mai	ling Address (Street and Nu		Rober		Zin Code)
Mand 2 shall as salth as 27 is er trau	1	Brenda Lawrence/Wife		4 Suitland				
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event men.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	1	position (Name of ematory or other place)	}		0c. Location - City or	
Itim nit. Parantitanti pritanti Injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		Mem. Park 22. Name and Address of Fa		/08 1	Landover,	, Md.
De legan		Janus E. William	nd	The House 814 Upshu	of W			/C.
	6	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not er					Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Mas onsequence of):	٥				Onoceana Dodon
Examiner			orisequerice oi).					
ed sit	iner	Sequentially list conditions, if any, leading to immediate course. First of deriving, Cause (Disease or injury	consequence of):					
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. Box 68760, death certificate be executed e attending physician and d for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 □ Ves 4 □ Pregnant at it	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of del Month	livery Day Year
P.O. at the d	hysi	1 Yes 2 No 9 Unknown				T		
	þ	Part II. Other significant conditions contributing to death but Renal Insufficients	_	underlying cause given in Pa	Part I.		acco use contribute to s 2 □ No 3 X Pr	
w request should	letec	Heart failure	}			24a. Was an		itopsy findings available
The tav	Completed	Renal Insufficience	15			autopsy perform	prior to	completion of cause of
Vital Re slcian: The transcription of certificate ha	Be	25. Was case referred to medical examiner?	U.		Place of Death	(Check onlone,		2.00
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ending ath. rr. Afte	atior	1 Natural 5 □ Pending (Month, Day, 1 2 □ Accident investigation	Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2			,,	
Division of Vital Records, I or Attending Physician: The law requires thater death. Director: After this certificate has been signed in by the funeral director, page 2 should be come to the property of the funeral director, page 2 should be come to the property of the funeral director.	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	y - At home, farm, si (Specify)	treet, factory, office	28	8f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	S S	29a. Certifier Certifying Physician: To the best of	my knowledge, dea	ath occurred at the time, dat	ite and place, a	nd due to the ca	use(s) and manner as	s stated.
the Ho iin 24 t the Fui ppletely	edical	(Check only one)	examination and/or i	investigation, in my opinion,	, death occurre	d at the time, da	te and place, and due	to the cause(s)
Vith Com	Σ	29b. Signature and title of certifier		29c. License numb			d. Date signed (Monti	
10		30. Name and address of person who completed cause of dea		D005	2446	1		2003
W		ALI RAHIMIAN, MD	1040	3 HOSPITA	ALDY	RIVE C	5-06 CI	INTON MD 2073.5
St Regist	ate trar	31. Date filed (Month, Day, Year) BEC 0 4 2008	s Signature	and)				1 10 0

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38638 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DOAM /Medical Town, or Location of Death 4a. Facility Name (If not institution, give street 4c. County of Death Examiner ate of Birth Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 💢 F ۷rs Director dence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Des 2 □ No Director TIMONE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent Ever in U Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: o. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry Give kind of work done during most of working √ife. DO NOT use retired) I Hygiene. Elementar (Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event, III lother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, I tate, Zip Code) Howere Baltimore, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 110155 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherescleratic Cardin Vascular Physician ears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner throcetenseer Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (oraș) consequênce of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown iis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**1** No 1 □Yes 200 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this funeral 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of After t 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of

30. Name and address of Tyotin

31. Date filed (Month, Day,

DEC 04

2008

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

821 N. Eut

29c. License number

D32158

St ste 407

29d. Date signed (Month, Day, Year)

Baltimore, MD

08

Registrar

29c. License number O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

December 2, 2008

04

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Bet. J

32. Registrar's Signature

29b. Sighafure and title of certifier

Laron Locke MD.

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mecuske **Physician** 2008 OM November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Year | If Under 24 Hrs. 5. Social Security Number If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrt. last birthday) 6. Sex **Funeral** Months Days Hours **X** M 2 □ F Director 212-20-2627 Usual Residence of Decedent 9/9/1925 PENNSYLVANIA death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Madical Examination at 1 ☐ Yes 2 ▼No Director PARKVILLE MD BALTIMORE 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 8656 BLACK OAK ROAD 21234 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Specify: WHITE 2 3 NWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene, Important: If Item 271s marked other than "any injury or other traumatic event, If a Ma. once. Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN MACHINERY 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be ATLEEN MOONEY ၉ PATRICK J. McCUSKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SHARON A. VAUGHAN/DAUGHTER 3024 TEXAS AVENUE BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place).
DULANEY VALLEY MEM. 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/6/2008 TIMONIUM, MD GARDENS 21. Signature of Funeral Service Licensee MOO217 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21286 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ocara disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, Examiner rrany, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence/of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) been signed by the should be detached 1 Tyes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔭 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform this certificate 1 □Yes 2 👿 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of D ath 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

P.O. Box 68760, of Vital Records, or Attending Physician; Division death.

Maryland 21215-0036

altimore,

Certification: To

3 ☐ Suicide

29a. Certifier

4 Homicide

To the Funeral Director; After th completely filled in by the funeral To the Hospital within 24 hours a To the Funeral C Hospital

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of reath (Item 23a) (Type, Print)

determined

31. Date filed (Month, Day, 32.

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend item 11 per fh 887 1-22-09 yt.

Amend 19a, perff g889 3/17/09 Fill of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1 1/18 1 - State Registrar Time of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 830 M Month Year **Physician** McQUEN-BEY 08 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 130 West Earleigh Heights Rd Park Severna Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 12 M 2□ F Months Days Hours Min. Director 218-14-7615 86 08 22 SC Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. To 7 is marked other than "natural", or items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Funeral Director 1 ☐Yes 27 No MD Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 130 West Earleigh Heights Rd 21146 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? ↓ ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🛛 No Completed by Specify: Specify: Black 3 ₩Widowed 4 ₩orced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade <u>Westinghouse</u> <u>Maintenance</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ John Henry McQueen-Bey Mattie M. Gordan 19a. Informant's Name/Relationship (Type. Print)
Sondra 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

MD 21146
130 West Earleigh Heights Road, Severna, McQueen-Bey Health tem 27 is Park Sandra 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial 12/4/08 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of the Important: If ite any Injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Annapolis, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 23a. P*rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death mediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery signed by the atter be detached for u 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Division** 5 ☐ Pending investigation 1 Natural 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the within 2 29b. Signature and title of gertifier 29d Date signed (Month, Day, Year) 21438 cembra 01,2008 321 Name and address of person who completed cause of death (Item 23a) Type, Print) ANNAPOUS MODIYO, MILHARL 32. Registrar's Signature DEC 0 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Juanita Nicholson 2339 PM November 26 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Baltimere Hosp, tal conter If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 ☑ F Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location ns 23a or 28a-f show must be notified at 1 ☐Yes 2 No WD by Funeral Director 10g. Citizen of What Country? 21208 Weyan oak usa r than "natural", or Items Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher 1 years is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ct. Apt. H. Glen Burne MD 2001 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. Governors 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 12-8-2008 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene 21. Signature of Funeral Service License Vaush 728 Liberty Rd. Randallstown 23a. Part 1. Enter the J sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he rt fahure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiovasculu Disease **Physician** rosclesutic /Medical Due to (or as a consequence of): Examiner KINSON Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Hypertension attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 MNo 1 □Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) соmpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0065425 November 26, 200 8

B

Registrar

31. Date filed (Month, Day, Year)

012

401

Randallstown 32. Registrar's Signature

Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MI

21133 -

Sterw Katz

Amend 17 & 18, per Fh g886 12/4/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 Dec. 2:00 P Nelson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Halethorpe 57 Randall Avenue If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye Aug. 31, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year. Days Months 1 □ M 2 🛛 F 1931 Maryland Director 213-28-9313 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show must be notified at Baltimore Halethorpe 1 Yes 2 No MD **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number P 21227 United States 57 Randall Avenue 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, Ite Modical Exercited. Once. 1 ☐ Never Married 2 ☐ Married Specify: White 1 □Yes 2X No Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dental Receptionist Dental 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Bruno William Insley ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1819 Palo Circle, Halethorpe, MD 21227 Carol Welsh - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition N Burial 2 Cremation 3 ☐ F 4 ☐ Ponation 5 ☐ Other (Specify) 3 Removal from State Loudon Park Cemetery 12-5-2008 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. e of Funeral Service 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Medical Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

should be filed within 72 hours after death with the Maryland

Pages 1 and 2

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be execut A hours often death	Function becomes the this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-trans
clan: The law requires that	ertificate has been signed b cctor, page 2 should be deta
Hospital or Attending Physical Applies after death	-uneral Director: After this cally filled in by the funeral dire

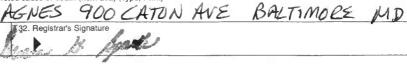
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25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 2 Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Medical Certifical 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

State Registrar 31. Date filed (Month, Day,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** John Joseph Nagle, Jr. 5:48 PM 2008 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/ABaltimore Keswick Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** New York November 18,1925 Months Days Hours 1X M 2□ F 217-54-9229 83 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1XXYes 2 □ No Baltimore Director Maryland | N/A10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21211 United States 700 W. 40th St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ es 2 □ No If Yes, Give Year or Dates: ₩₩ II 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) home construction manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jenny Healey John Joseph Nagle, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Timonium, MD 21093 11656 Greenpoint Rd. John J. Nagle, III/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem Gard Dec. 4,2008 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) John O. Mitchell Funeral Services of Dulaney Valley 200 E. Padonia Rd. Timonium, MD 21093 P. 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ()ementia **Physician** Har disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural within 24 hours arter community to the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

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State

30. Name and address of person who completed sause of death (Item 23a) (Type, Print) WA.R. (Ley CAMC 6701 N-CC

31. Date filed (Month, Day, Year)

DEC 0 4 2008

32. Registrar's Signature

D2520s

N. Charles Ste

December 2, 2008

Bolts and Zizok

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** December Pietruszka Eilleen 1245AM Audrev 700F /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Season Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 11, 1956 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

MT 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 🖾 F MD 52 220-74-3973 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The tradical Examination of the profile of the second of the sec Director 1 ☐ Yes 2√ No MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 Ferndale Road 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No White If Yes, Give Year or Dates: Specify: Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Machinist Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Cavanaugh Audrey Murray ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mr. Daniel Pietruszka/Husband 8 Ferndale ROad Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast **Physician** Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be executed physician and is the burial-transit С Due to (or as a consequence of): Box 68760, Physician/Medical ası attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. ed by the a 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 ☐Yes 2 No 1 ☐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of funeral direction Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A

completely filled in by the fu investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific Deember 2 2008 of person who completed cause of death (Item 23a) (Tur 835 Smith Avenue Baltimore MD Tlerce 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 25 per me, g886, 12/15/08dhb

State Registrar

Per Amend State Registrar

Per Amend Item 25 per me, g886, 12/15/08dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2008 06' Novembo Kiara Pinson 30 <u>Kori</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimoc ltosp.tel Bultimore of If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 3 F **Director** 06 MD 213-37-1614 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 U.S.A. <u>3726 Belle Ave</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel may injury or other traumatic event, the Wedical Evantral and. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student School 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brian Pinson Kisha Stanley ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3726 Belle Ave, Baltimore, Kisha Phillips-Mother Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 Denation 3 Removal from State 4 Dopnation 5 Other (Specify) King Memorial Park 12/6/2008 Woodlawn, Md 21. Signature of Funeral Service Licensee March F/H West 22. Name and Address of Facility 300 Wabash Ave, Baltimore, Md 21215 23a. Patt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mult-System organ **Physician** /Medical Due to (or as a consequence of Examiner Cardine Due to (or asia consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATIO NUMBAIL Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, sendomonus Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner?

Yes 25th Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After t 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 30 2008 6375 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID KLEID mp 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

DEC 0 4

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 3 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау Joseph A. Ritz, Sr. December 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltin da one Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)

Aug. 12, 1922 7 Age (In vrs. last birthday) . Social Security Number Months Days Hours **X**X м 2□ F 86 Aug. Pennsylvania 097-16-7401 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🏋 🕅 No Baltimore Owings Mills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 U.S.A. 25 Pleasant Hill Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XXYes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 □ Yes 🏋 🕅 No Specify: Specify: White XXWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Auto Repair Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Kuh1 Frank W. Ritz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25 Pleasant Hill Rd. Owings Mills, MD 21117 Thomas G. Ritz / Son 20b. Place of Disposition (Name of cemetery, crematory or other Druid Ridge Cemetery 20a. Method of Disposition 20c. Location - City or Town, State XI Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/05/08 Pikesville, MD 21. Signature of sortal service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ue to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3

Ectopic pregnancy Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 ⊠No 1 ☐Yes 2 ☐No 1 □Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Enpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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MD

Item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the "Neucal Examinating the notified at

12 should be filed with and Mental Hygier 7 Is marked other the

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau

Baltimore, Maryland 21215-0036

physician and the burial-transit attending p signed by the a P.O. Division of Vital Records,

certificate After this or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician/Medical

≥

Completed

Be

Certification: To

Medical

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 Natural 2 Accident

4 Homicide 29a. Certifier (Check only one)

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Party H. Wowetowor

D0063327

29d. Date signed (Month, Day, Year) 12/02/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIZAW WOLDEHIWOT, 9000 PCA 1. Date filed (Month, Day, Year) 32. Registrar's Signature 9000 FRANKLIN SQUARE BRIVE, BALTIMORE, MIS 31. Date filed (Month, Day, Year)

State Registrar

DEC 0 4 2008



Hospital

00-09030	Flease Type of Title III Black III actions to the second s
Samuel Theodore Reynolds	State of Maryland / Department of Health and Mental Hygir
	Outilizate of Dooth

2008 38648

Camber Theodore	1-	For State	tato of that yet	Certi	ficate of	Death				. No.	. 0 0	0 000 .
Physician		egistrar Decedent's Name (First, Midd	ile,Last)					2. D	ate of Death	Day Year	1	Time of Death 2328 hrs
Medical Examin		SAMUEL TH	EODORE R	EYNOLDS					ovember :	23, 2008		23201115
1		a. Facility Name (if not instituti	on, give street and no		4	b. City, Town, or	Location of	f Death		4c. County of	Death	
,	ь	Union Memorial Hosp	oital			Baltimore		- 10	- 1 - C Pi-st	N/A (MM/DD/YYYY)	0 Birthol	ace (State or
Funeral	5	Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Yes			Date of Birth	(MM/DD/YYYY)	Foreign N	ARYLAND
Director		220-16-8254	1 X M 2 F	8	33 Yrs.	Wiontins	3 110010		11/08/	1925	Countr	У)
		Isual Residence of Decedent									110	d. Inside City Limits
Au a	1	0a. State 10b. County	/	10c. City, T	own or Locati	on						Yes 2 No
show ree.	اخ	MARYLAND N/	'A	I	BALTIM				- 140	g. Citizen of Wha		21
S 22 Maryland Maryland 28a-f show d at once.	Director	0e. Street and Number				10f. Zip Code			10	g, Citizen of wha	it Country	·
he M	ä	4058 EDGEWOO	DD RD			212				U.S.A		Direction 1
with 1 1s 23;	<u>e</u> -	11. Marital Status	12. Was De	ecedent Ever in U.S Forces?	i. 13. Wa	s Decedent of Hi	spanic Orig	gin? (Specif . Puerto Rica	y Yes or No- an, etc.)	14. Race - White,		Indian, Black,
leath r iten	Funeral	1 Never Married 2	1 XXYes	2 No		_				C#.#	BLAC	אר
5-0036 led within 72 hours after death with the Maryfand Hygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	by F		Divorced If Yes, Give Your Dates:			Yes 2 X N			4000	Specify: 16b. Kind of Bus		
ours a		15. Decedent's Education (Sp			16a. Deceder during m	nt's Usual Occupa nost of working lif	e. DO NOT	use retired))	TOD. Talla of Das		
72 h 22 h 23 l 23 l 23 l 23 l 23 l 23 l 2	Completed	Elementary/Secondary (0-1)	2) College	(1-4 or 5+)						BETH S	STEEL	
nithin rithin ritedia	ᇍ	12th grade			MOBII	LE EQUIP	MENT 18 Mother	r's Name (Fi	rst. Middle, N	laiden Surname)		
5-0036 iled within 7 Hygiene. I other than		17. Father's Name (First, Midd	ile, Last)							YNOLDS		
21215-Culd be filed v Mental Hygi marked oth	a	CHARLES REY 19a. Informant's Name/Relation	NOLDS		19b. Mailin	a Address (Str				ber, City or Town	n, State, Z	ip Code)
O d d is it	٤									,Marylar		
MD nd 2 sho afth and m 27 is raumati	-	Clifton Reyno	lds/Nephe	20b. F	lace of Dispo	sition (Name of c			ate	20c. Location -	City or To	own, State
of He If ite		1 XXBurial 2 Cremat	tion 3 Removal	from State	rematory or o			1,,,	4 00	01171100		C MADVI AND
Page ment tant:		4 Donation 5 Other	Specify:	GAI	100	FOREST Name and Addre	es of Facilit	12-0				S,MARYLAND
Baltimore, ME permit, Pages 1 and 2.s Department of Health a Important: If item 27		21 Sonature of Funeral Serv	ice Licensee		l V	VILLIAM L206 W N	C BRO	WN COL	MMUNIT	Y FUNERA	∤L HC	ME P.A.
E.E.O.S W	_	parlana (23a. Part I. Enter the disease,	or complications tha	t caused the death	Do not enter	the mode of dyin	g, such as	cardiac or re	espiratory arr	est, shock, or hea	art	Approximate Interval
Physician edical		failure. List only one cau	use on each line.									Between Onset and Death
iminer	1	Immediate Cause (Final diseasor condition resulting in death	ase a. Uros	epsis s a consequence of	6).				_			
		or condition resulting in deal	b Due to (or a	s a consequence of	.,.				4			
	-i	Sequentially list conditions, if any, leading to immediate		s a consequence of	f):							
	Examine	cause. Enter Underlying Cau (Disease or injury that initiate			£).							
1 × 5	iz	events resulting in death) La	st Due to (or a	s a consequence o								
executed an and all - transi		THE WHITE HEED	a	23a,pt	.11,27	per me	g886	12-20	-08 √t			
- e - E - E	Medical	X UNPENDED		es, outcome of preg				_		23d. Date of	f delivery	
760 ficate b g physics s the bu	ΝŽ	IF FEMALE: 23b. Was decedent pregnant	in the 23c. If ye	es, outcome of preg ve birth	2 F	etal death	3 Ector	pic pregnanc	су	Month	Da	ay Year
c 68 certi endin use a	cial	past 12 months?	4 Pr	egnant at time of de	eath 5 (Other (Specify)						1
Division of Vital Records, P.O. Box 6876 the Ilospiral or Attending Physician: The law requires that the death certificath hin 24 hours after death. The Inversal Director: After this certificate has been signed by the attending phymplesty filled in by the funeral director, page 2 should be detached for use as the	Physician	1 Yes 2 No 9		nknown		-		Dort I	23e Did	tobacco use conti	ribute to t	ne cause of death?
at the	4	Part II. Other significant co	nditions contributing	ig to death but not r	esulting in the	e underlying caus	se given in i	ranı. İsones		es 2 V No 3		
, P.O. res that the signed by	q p	Coronary A	rtery Disc	ease,Peri	phoral	vascu	Lar D		24a. Was			opsy findings available
ords, » requir s been s should I	lete								auto	psy	prior to co death?	ompletion of cause of
e law e has ge 2 si	Completed by										1 Y Yes	2 No
of Vital Records, ng Physician: The law require After this certificate has been signered director, page 2 should the statement of the statemen		25. Was case referred to me	dical			26.P	ace of Dea	th (Check or	nly one)			
ital sician is ceri	Be B	examiner?		Inpatient 2	ER/Outpatie	ent 3 DOA	Other,	Nursing	Home 5	Residence 6	Other	
of Vil ing Physic After this	2	1 Yes 2 No 27. Manner of Death	28a. D	ate of Injury	28b. Time o	of Injury 28c.	Injury at Wo	ork? 2	28d. Describe	how injury occur	rred	
Iding	l is		Pending	lonth, Day,Year)		1	Yes 2	1				
Division tal or Attendi us after death. al Director: A	Certification:		Investigation 28e.	Place of Injury - At I	home, farm, st	treet, factory, offi	ce building,	etc.	28f. Location or Town,	(Street and Num	ber or Ru	ral Route Number, City
Div.	1 1		Could not be determined (Spe	cify)				4				
Divisior Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		20- Contifier	ng Physician: To the	best of my knowle	dge, death oc	curred at the time	e, date and	place, and o	due to the ca	use(s) and mann	er as state	ed.
the II	Medical	(Check only one) 2 Medical	Examiner: On the ba	asis of examination ner stated.	and/or investi	gation, in my opi	nion, death	occurred at	the time, dat	e and place, and		
No. Con	ĕ	29b. Signature and title of co		lei stated.		29c. Lic	cense numb	per				nth, Day,Year)
10)	1	1 Dun	M lil	IMO		0	.C.M.E.			Decembe	r 3, 200)8
(Blow)	1	30. Name and address of pe	erson who completed	cause of death (Ite	m 23a)					7-		
18 Dem	Ť	Donna M. Vincent		nt Medical Exa	aminer 1	11 Penn Str	eet, Balti	imore, MI	D 21201			
	State	01 5-1-61-141-15 5-11	(ear) 3	2 Registrar's Signa		A.P.						
Regi		2500		Colum &	V 19							
DHMH 17 Rev 1	/2001				ORIGII	NAL						

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Physician /Medica
Examine

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sta

1.	Decedent's Name			1 -	. 1 1					2	. Date of De Month	ath	V	Vear	3. Time of	Death
L		Marie	Eve	elyn R	idgle	ey					Dec.	2 ^{Day}	20	008 ^{ar}	10:5	7P.N
4a.	Facility Name (If Carroll								or Location of I	•				of Death Carr	coll	
	Social Security Nu 217-38-6 sual Residence of	245	6. Sex 1 □	M 2LIF	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Yea Months Day		Hrs. 8 Min.	Date of Bir (Month, Da 3 / 25 / 1	th 19. <i>Year)</i> 941		9. Birth Con	nplace (State untry) MD	or Foreig
_	a. State	10b. County			1	0c. City, T	own or Lo	ocation							10d. Inside C	ty Limit
	MD	Fred	leri	ck		New	Wind	sor							1 ☐ Yes	2 🖰 N
106	e. Street and Num	nber						10f. Zip Code)			10g. Cit	izen of V	What Cou	untry?	
	14702 Oa	k Orch	nard	Rd.					776						USA	
11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ □ Nourced 12. Was Decedent E Armed Forces? 1 □ Yes 2 □ □ Nourced 15 Yes, Give Year or Dates:					orces? 2 1 No ive	er in U.S.		Was Decedent o If Yes, specify Co 1 □ Yes 2 2 N		n? (Speci Puerto R i	fy Yes or No can, etc.)	-		ck, White	rican Indian, , etc. hite	
		15. Deceder	nt's Educ	ation		1	I6a. Dece	dent's Usual Occ	upation			16b. Ki	ind of Bu	usiness/li		
_	(Speci	ify only highe	st grade	completed) College ((Give	kind of work dor DO NOT use reti	e during most o	f working					-	
Ш	10						Ai	.de	1						heran V	ill
	'. Father's Name (18. Mother's	,				ne)		
	Henri E.						10b M-201	na Address /Or-			lae Ke			Ctata 7	in Cadal	
19	9a. Informant's Na							ng Address (Stre								
20:	Colleen a. Method of Disp		s/pa	ugntei		20b. Plac		02 Oak O esition (Name of matory or other p		Dat					Town, State	
	1 ☐ Burial 2 🛣 4 ☐ Donation	Cremation 5 Other (S	Specify)		State		h Car	roll Cr	ematory	12,	/6/08			ld,		
	Cianotus of Eur	paral Sanciaco								_						
23	3a. Part 1. Enter the shock, or hear	ne dise se, or rt failure. List	License r complice t only on	cations that	caused the	e death. I		2. Name and Add Burrier 1212 W. ter the mode of d	-Queen -Old Lil	bert	Rd.,	Win			MD 2178 Approximat Interval Ber	34 e ween
Im dis re	3a. Part 1. Enter th	ne dise se, or t failure. List Final n dittions, mediate	Zen r complic	Due to	each line.	consequen	Do not ent	Burrier 1212 W.	-Queen -Old Lil	bert	Rd.,	Win		1d,	MD 2178 Approximat	84 e ween
Im dis res	Ba. Part 1. Enter the shock, or hear smediate Cause (I sease or condition is sulting in death) sequentially list con any, leading to immuse. Enter under attained events sulting in death) L FEMALE: B. Was decedent in the past 12 r Yes 2. 9 Unknown	ne dise se, or trailure. List Final n n n n n n n n n n n n n n n n n n	r complicit only on	Due to Due to Due to	(or as a control of the control of t	consequent consequent	Do not ent lice of): lice of): lice of):	Burrier 1212 W. ter the mode of c	Old I.il	bert	espiratory a	Win	afie 23d. Dat Mo	1d,	Approximate Interval Bet Onset and IP3 OF J	34 e ween Death Sugar
23 Im distress See if a contract that ress	Ga. Part 1. Enter the shock, or hearn mediate Cause (I sease or condition southing in death) equentially list con any, leading to immose. Enter Union at a tributation of the control of	ne dise se, or trailure. List Final n n n n n n n n n n n n n n n n n n	r complicit only on	Due to Due to Due to	(or as a control of the control of t	consequent consequent	Do not ent lice of): lice of): lice of):	Burrier 1212 W. ter the mode of c	Old I.il	bert	espiratory a	Winnest,	23d. Dat Mo	1d,	Approximation and interval Bell Onset and IV-3 TOK-J	34 eween Death 44
See if a Castharres	Ba. Part 1. Enter the shock, or hear mediate Cause (I sease or condition is sulting in death). Bequentially list con any, leading to immuse. Enter Undarause (Disease or i at initiated events sulting in death). Let the subsequent in the past 12 r 1	ne dise se, or trailure. List Final number of the conditions, mediate number of the conditions as the conditions of the	r complicit only on	Due to Due to Due to	(or as a control of the control of t	consequent consequent	Do not ent lice of): lice of): lice of):	Burrier 1212 W. ter the mode of c	Old I.il	bert	23e. Did t	Winnest,	23d. Dat Mo	te of delionth	Approximate Interval Bet Onset and I/13 TOF J	e ween Death Peath?
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Im distress See if a contract that ress IF 23	Ga. Pari 1. Enter the shock, or hear mediate Cause (fesease or condition southing in death) equentially list condany, leading to immuse. Enter Under ause (Disease or it are initiated events suiting in death) L FEMALE: B. Was decedent in the past 12 r 1 Yes 2 J Unknown It II. Other significations of the condens of	ne dise se, or trailure. List Final number of the failure in trailure. List Final number of trailure in trailure i	ons control be	Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	each line. (or as a c (or as a c (or as a c (or as a c tcome of birth 2 [gnant at tirnown leath but r Inpatient of Injury tth, Day, Y	pregnancy Fetal deme of deat consequent pregnancy Fetal de me of deat and resultin 2 □ ER (ear) 28	Do not ent lice of): lice of of): lice of): lice of): lice of): lice of): lice of): lice of of):	Burrier 1212 W. ter the mode of c CA Ectopic pregna Other (specify) Inderlying cause of the content of	ncy 26. Place of ork? 27. Value of ther: 4 \(\text{Nurser} \) Nurser ork? \(\text{Yes} \) 2 \(\text{Normal Nurser} \)	f Death (ing Home	23e. Did t 1 24a. Was autor perfo 1 □ Yes Check only of the control of the cont	obacco u Yes 2 an Dosy Jormed? 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	23d. Date Mo	te of deli- onth ribute to 3 Pro Were aut prior to c death? 1 Yes er (Special	Approximatiniterval Bet Onset and IP-3 TOR-J	ween Death Year Johnnow Available ause of
IF 23	Ga. Pari 1. Enter the shock, or hear inmediate Cause (I sease or condition is sulting in death) adjusted by the sease of condition in the past 12 r. 1 Yes 2. 2 9 Unknown Yes 2. 4 9 Unknown Yes 2. 4 9 Unknown Yes 2. 4 9 Unknown Yes 2. 4 9 Unknown Yes 2. 4 9 Unknown Yes 2. 4 4 4 4 4 4 4 4 4 4	ne dise se, or ort failure. List Final n ditions, mediate dispussion injury injury injury injury injury injury injury injury ast	ons contact Herman and Physics	Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	(or as a c (or as a c (or as a c (or as a c tcome of birth 2 [nant at tirnown leath but r Inpatient of Injury th, Day, Y e of Injury ing, etc. (pregnancy Fetal deme of death	Do not ent lice of): lice	Burrier 1212 W. ter the mode of content and the mode of content and the mode of content and the mode of content and the mode of the mode o	ncy 26. Place of other: 4 \(\triangle \) Nursignry at ork? Yes 2 \(\triangle \) No e	f Death (ing Home 28	23e. Did t 1 24a. Was autor performed. Describe I Location (: City or Town	obacco u Yes 2 an osy 2 Ano one) dence how injur Street an wn, State	23d. Dat Mo use conti No 24b. \ 6 \colon ord Numb	te of delionth ribute to 3 Pro Were autriprior to codeath? 1 Yes mer (Specured)	Approximate Interval Bet Onset and Interval Bet Onset and IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	ween eath? Year Johnnow Work Johnnow Johnno
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Im distress of a second	Ga. Part 1. Enter the shock, or hear inmediate Cause (is sease or condition and inmediate Cause). Beautiful in the condition of the condition	ne dise se, or or trailure. List Final number of the failure in trailure. List Final number of trailure. List Final number o	ons contact Herman Physics Examin	Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	(or as a composition of the comp	pregnancy Fetal deme of death	Do not ent lice of): lice	Burrier 1212 W. ter the mode of co A Ectopic pregna Other (specify) Int 3 DOA The 28c. In W. M. I reet, factory, office h occurred at the westigation, in more	ncy 26. Place of ther: 4 \(\text{ Nurser jury at ork?} \) 1 Ves 2 \(\text{ No de and y opinion, death} \)	f Death (ing Home 28	23e. Did t 1 24a. Was autor performed. Describe I Location (: City or Town	obacco uves 2 an osy ormed? 2 one) dence how injur	23d. Date Moo	te of delimith ribute to 3 Pro Were autriprior to codeath? 1 Yes per (Special Company of the company of t	Approximate Interval Better State St	ween beath? Year Johnnow Wear Johnnow Johnn

DHMH 17 Rev 1/2001

Registr

SOC 7. Age (In yrs. last birthday)
92 Yrs. 1 ☐ M 2 💢 F

10c. City, Town or Location

10g. Citizen of What Country? 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.

Reg. No.

November 21

8. Date of Birth (Month, Day, Yeer) Oct. 20, 1916

2. Date of Deeth

Month

4b. City, Town, or Location of Deeth

If Under 24 Hrs. 8. Date of Hours Min. (Month,

21,2008 4c. Country of Deeth Balt

3. Time of Death

imore

West

Birthplace (Stete or Foreign Country)

:51 PM

Virginia

10d. Inside City Limits

1XYes 2 No

3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unemploye

Specify:

1 ☐ Yes 2 No

Certificate of Death

If Under 1 Year Months Days

Months

18 Mother's Name (First, Middle, Maiden Sumame)

16b. Kind of Business/Industry

White

17. Father's Neme (First, Middle, Last)

Robert Koderic 19a. Informant's Name/Reletionship (Type, Print) (Sister)

Stonebreaker 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 22960 12/8/2008 Orange Virginia 20b. Plece of Disposition (Name of cemetery, crematory or other place) cossing

Method of Disposition 1 ☐ Burial 2 区 Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

GreenMount cematoru

21. Signature of Funeral Service Licensee

22. Name and Address of Facility. Funeral Home, P.A. ve. Balto. Md. 21216 Joseph L. W. North Ave 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Failure

Due to (or as a consequence of)

Dementio

CERTIFY Due to (or as a consequence of)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 E No 3 ☐ Probably 4 ☐ Unknown

Mental Retardation

24a. Was an autopsy performed?

ION APPROVED BY

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No

26. Plece of Death (Check only one) Hospital: 1 | Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA

examiner? 27. Manner of Deeth 1 Naturet 5 Pending

25. Was case referred to medical

28a. Date of Injury (Month, Dey Year) investigation 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Yeer)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) ASMANTIL

5400 Old Court Rd. Suite Sandallstown, Md. 21133

State Registrar 31. Dete filed (Month, Day, Year) 2008 DEC 0 4

IVIRA

32 Registrar's Signature

DHMH 16 Rev 6/95

within 24 hours after death. To the Funeral Director: After

Physician /Medical

Examiner

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/Medical Examiner

Be Completed by

Medicai Certification: To

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	State of Maryland / Department of Healt Certificate of Dea	
Physician /Medical	1. Decedent's Name (First, Middle, Last) TOTGE RVCTA 4a Fecility Name (If not institution, give street end number) 4b. City	2. Date of Death Month Day Year November 23 2008 1729 7, Town, or Location of Death 4c. County of Death
Examiner Funeral Director	Good Samaritan Hospital B	det 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fore
the Maryland 28a-f ahow notified at	10e. State 10b. County 10c. City, Town or Location 10c. City Town or Locati	10d. Inside City Limi 1 ∑ LYes 2□N
be filed within 72 hours effer death with the Marylend tell Hygiene. d other than "natural", or items 23a or 28e-f show event, the Modical Experiment must be notified at sevent, the Modical Experiment must be notified at Be Completed by Funeral Director	10e. Street end Number 18 Driftwood Ct. 21221	10g. Citizen of Whet Country? LA SA Origin? (Specify Yes or No- 14. Race - American Indien,
ours effer d iral", or flem LExandrer. d by Fun	1 Never Married 2 Married 1 Yes, specify Cuban, Mer 1 Yes, Give 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify Cuban, Mer 2 No Specify Cuban, Mer 2 No Specify Cuban, Mer 2 No Specify Cuban, Mer 3 Wildowed 4 Divorced Year or Dates:	city: Puerto Rica Rica Specity: Latino
be filed within 72 hours tel Hygiene. d other than "natural", event, tre Modical Exe Be Completed by	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usuel Occupation (Give kind of work done during life. DO NOT use retired)	most of working 16b. Kind of Business/Industry
2 should be filed with end Mentel Hygiene is marked other tha aumatic event, the To Be Com	17. Father's Neme (First, Middle, Last) Miguel Rivera 18. N	Inchelia Ramos
1 end Health em 27 ither tr	19e. Informent's Name/Relationship (Type, Print) (Sister) 19b. Mailing Addrass (Street and No. 19b. Mailing Addrass (Stree	umber or Rurel Route Number, City or Town, Stete, Zip Code) LSE Lane Balto. Md. 2/26 Date 20c. Location - City or Town, State
pemit. Peges Depertment of Important: If its any injury or o	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signapure of Funeral Service Licensee 22. Name and Address of Funeral Service Licensee	tory 12/3/2008 Batto, Md.
Deport I mport	23a. Perty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shops or heart failure. List only one cause on each line.	ASS Funeral Home, P.A. DITH Ave. Balto. Md. 21216 has cardiac or respiratory arrest, Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. A SCVD	Onset and Death
uted ansit miner	b Due to (or as a consequence of):	
Attending Physician: The lew requires thet the death certificate be executed redeath. ector: After this certificate has been signed by the ettending physician end by the funerel director, page 2 should be deteched for use es the buriel-transit. iffication: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of):	
sian: The lew requires that the death certific artificate has been signed by the ettending potor, page 2 should be deteched for use as Be Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I. 23b. Did tobacco use contribute to the cause of dea
w requires the s been signed is should be def		24a. Wes an autopsy performed? 24b. Were autopsy finding available prior to completion of cause of death?
idlan: The lew certificete has rector, pege 2:	25. Was case referred to medical 26.1	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
Physicla this cert rel direct	examiner? Hospital: 1 Inpatient 20 ER/Outpatient 3 DOA Other: 4	□ Nursing Home 5 □ Residence 6 □Other (Specify)
tending P death. for: After t the funer ication:	27. Manner of Death 1	28d. Describe how injury occurred 2 □ No 28f. Location (Street and Number or Rural Route Number,
Patrice Te	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, da	City or Town, Stete)
within 24 hours within 24 hours completely filled	(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion and manner stated.	death occurred et the time, date and place, and due to the cause(s)
T W W T W T W T W T W T W T W T W T W T	29b. Signarure and title of certifier 29c. License num 257.7	19/01/00
1	30. Neme and address of person who completed cause of death (Nem 23a) (Type, Print) Way August Way San (Type, Print) 31. Dete filed (Month, Day, Year) 32. Registrar's Signature	Woods Rose. MD 21234
State Registrar	DEC 0.4 2008	
MH 16 Rev 6/95	ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** SMITH 1128 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 217-24-835 1 M 2 L Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show items 23a or 28a-f sho ner must be notified at 1 ☐ Yes 2 ☐ NO Director 10e. Street and Numbe 10g. Citizen of What Country? alaa onmar Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Armed Yes Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify ģ 3 ₩idowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Jurse university 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surneme) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela 3305 hichmoud WDSISIB Health tem 27 Ave altimore Department of Health Important: If Item 27 any injury or other tr once. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Dedrial 2 Cremation 3 Removal from State Baltimore. 12.6.2008 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services 4905 York Ad Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Due to (Ir as a consequence of): **Physician** Organ disease or condition resulting in death) /Medical Examiner holangitis Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed holanglo (arcinoma Due to (or as a consequence of): resulting in death) Last Box 68760 Physician/Medical IF FEMALE certificate has been signed by the attending firector, page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 🗌 No 1 Tes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Avatural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, DEC 04 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINS ENTER TER RROLL ARRO L1 HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. 1 □ M 2√2 F Director 215-26-9078 78 8/13/1930 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It was 23 or 28a-f show other than "natural", or items 23a or 28a-f show other traumatic event, the Maries Evantine must burnathed an 1 ☐ Yes 2 📉 No Director WESTMINSTER MD CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 2426 SYKESVILLE RD. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after (Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Completed by Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY BOARD OF EDUCATION 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CARROLL ANDREW FROCK MADELEINE BITZEL ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2426 SYKESVILLE RD., WESTMINSTER, MD 21157 GARY E. SAYLOR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) DEER PARK CEMETERY 12/5/08 SMALLWOOD, MD Signature by unbrain Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the "hease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ONEAL BLEEDING IVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician and I be detached for use as the burial-transit Exam Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown نہ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, DISSEMINATING INTRAILASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Il or Attending Platter death. 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Hospital 29a, Certifier 🕯 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed, (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

CHANARON

DEC 0 4

31. Date filed (Month, Day, Year)

ORIGINAL

WASHINGTON

820

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Vovember 25,2008 eam /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Days Months Hours Min. Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unit. If item 27 is marked other than "natural", or heart show may or other traumatic event, it we wait a Euring or other traumatic event, it was the standard of th 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Wes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 XWidowed 4 ☐ Divorced Iac 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Andrew

19a, Informant's Name/Relationship (Type. Print Frankdaughter)

Thompson ဥ 9b. Mailing Address (Street and Number or Ru Doute Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. Method of Disposition 20b. Place of Disposition (Name o cemetery, crematory or other 1 Burial 2 ☐ Cremation 3 Removal from State Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) Son 22. Name and Address of Facility
Joseph L. Russ 21. Signature of Funeral Service Licenses W. North Ave. Balto. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) ENIPHERAL VAJCULAL DIJEASE **Physician** SK CEMPLICATIONS YRALI /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed cate has been signed by the aftending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 2 No certificate 2 No 1 Tes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) WOSPICE After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 ☐ Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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TOWSIN MI)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Joseph Saynuk 12-03-2008 635 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1**X** M 2□ F 83 04-29-1925 219-18-3136 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Baltimore Perry Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18 H Brook Farm Ct 21128 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 College (1-4or 5+) Elementary/Secondary (0-12) Tool & Die Maker Government Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alexander Saynuk Valeria Filipkowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Saynuk (Wife) 18 H Brook Farm Ct Perry Hall, MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12-04-2008 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licenses Cell Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 24a. Was an autopsy performe 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of

Examiner burial-transit attending physician the as signed by the a Records, Division or Vital

s certificate has b irector, page 2 sl

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

MD

7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified

2 should be filed within and Mental Hygiene.

is marked other than

Important: If item 27 any injury or other tr

Physician

/Medical

any in once.

Examiner

Physician/Medical

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Completed

Be

P

Natural

29a. Certifier

2 Accident

3 ☐ Suicide

4 Homicide

(Check only

31. Date filed (Month, Day, Year)

Certification:

the Hospital or Attending Physician: After this within 24 hours after death To the Funeral Director:

Medical

State

29b. Signature and title of certific

5 Pending investigation

6 ☐ Could not be determined

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ess of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

500

32 Registrar's Signature

Chesapoake Dr. Bel A. V. M. 31014

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Day **Physician** LUNSTALL AISHA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Moeth, Day, D 8 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 219-33-6 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? Of, Zip-Code 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Never Married 2 Married 2 🗆 N6 1 ☐ Yes 2 No Maryland 21215-0036 Specify: ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Decedent's Subala Occupation (Give kind of work done during most of working life, DO NOT use retired) d 2 should be filed within ; h and Mental Hygiene. 7 Is marked other than "r ondary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Su 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic ever netra 19b. Mailing Address (Street and Number or Rural Route Number, City or 19a. Informant's Name/Relationship (Type. Baltimore, 20c. Location Burial 2 Cremation 3 Removal from State 5 Other (Specify) 21. Signature of F Service 101553 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** EPS15 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-tran Due to (or as a consequence of): resulting in death) Last Box 68760, Physician/Medical ed by the attending detached for use a IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal dea ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? eral Director; After this certificate has been signed filled in by the funeral director, page 2 should be de No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 🗌 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 🗌 No 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: Injury 1 Natural (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No М within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 MUANOUIL 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

DEC 0 4 2008

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Eliza L. Thompson a ^M 11 28 2008 3:00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore
If Under 1 Year | If Under 24 Hrs. Union Memorial Hospital 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Min 1□м аДу Hours MD Director 4-25-1931 214-28-1850 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov ral", or items 23a or 28a-f shore 1 X Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1501 E. 36th permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 239 any injury or other traumatic event, the Marked Street 21218 U SA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify. þ Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary School Elementary/Secondary (0-12) College (1-4or 5+) 12th grade N/A School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Macer 2 Cora Neal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband 1501 Freddie R. Thompson Ε. 36th Street Balto, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Thompsontowne 12-6-2008 East New Market, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H ME tack condrae 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) MYOCAPOLAZ **Physician** /Medical Due to (or as a consequence of): Examiner CORENTAM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Yes 2 No Hospital: 1 Inpatient ER/Outpatient 3 DOA 2 Certification: To 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After 1 Natural (Month, Day, Year) Injury 5 Pending To the nusping after death.

To the Funeral Director: After the funeral birector after the funeral by the funer 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANUEL PAMCE YOR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 38658 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day 540 PM Robert Donald Thomas November 25, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchey Hospice Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 ₩ 2 □ F 219-28-2878 78 22, 1930 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits X ☐Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1715 Wilkens Avenue 21223 United States 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Correctional Center State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Thomas Theresa Madelaine 19a. Informant's Name/Relationship (Type. Print) Steven M. Shaffer - Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 Weddel Avenue, Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery | 12-2-2008 4 □ Donation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Fune al Service L 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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Examine

Physician/Medical

Be Completed by

Medical Certification: To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Event must be notified at once.

Baltimore, Maryland 21215-0036

physician and the burial-trans attending pl

his certificate has been signed by the director, page 2 should be detached filled in by the funeral Hospital or Attending within 24 hours after deat To the Funeral Director:

Division of Vital Records,

	d.	nce orj.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	eath 3 Ectopic p			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulti	ng in the underlying c	ause given in Part I.		
25. Was case referred to medical			26 Place of De	ath (Check only one)	NO THES ZEING
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3 DO	Othori		6 Dother (Specify)
27. Mann of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	8b. Time of Injury M	8c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	
3 Suicide 6 Could not determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory	, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge: On the basis of examination and manner stated.	edge, death occurred on and/or investigation	at the time, date and plac , in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifie	11	290	: License number	29d.	Date figned (Mghth, Day, Year)
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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38659 Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day , 04124 **Physician** Illiam ovember /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Salfamore Burnew Medical 8. Date of Birth (Month, Day, Year) antigoth If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Months Days Hours Min. 169-40-8420 62 November Pennsylvania Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Many Department of Health and Mental Hygiene. Important: If item 27 its marked other than "natural" or items 23a or 28a-1 sh any injury or other traumatic event, its involved. Director 1 ☐ Yes 2 XNo Dundalk Maryland | Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4519 Greencove Circle 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Years Elementary/Secondary (0-12) Field Sales Engineer 12 years Electrical s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Wolsfield Nancy Jane Gastineau 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Susan Wolsfield Wife 4519 Greencove Circle, Dundalk, Maryland 21219 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20c. Location - City or Town, State Pages 1 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 29, 2008 Baltimore City, MD. Signature of Funeral Service Licenses connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease of shock, or heart failure. List complications that caused the death. only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LOURS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed ician and burial-trans Due to (or as a consequence of): Box 68760, physician sthe burial Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s certificate 2 🗆 No 1 ☐ Yes 1 □ Yes of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA npatient Certification: To After thi funeral of Manner of Death
Natural
Control
Control Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending Division Injury death. 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: A letely filled in by the fu Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signatu 29c. License number November 25,2008

State Registrar Brion

31. Date filed (Month, Day, Year) DEC 0 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rom Silverman MD 4410 Footen Areau,



Baltimore, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla		partment of F ertificate of		_	giene Reg. No	008	38660	J
	Physicia		1. Decedent's Name (First, Middle, Last) PEAR LINE	N. W	RIG	-HT		2. Date of De Month	ath Day	2 oo	3. Time of Death	1
	/Medic Examin		4a. Facility Name (If not institution, give str				r Location of Death		4c. C	ounty of Deat		
É			UNIVERSITY OF MARYL 5. Social Security Number 6. Sex		rs. last birthda		IMORE	8 Date of Bir		√A 9 Birt	hnlace (State or Foreig	an an
п	Funeral Director			A AFTER	8 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 7 – 26	iy, Year) -1930	0	hplace (State or Foreig untry) S.C.	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or	Location					10d. Inside City Limits	
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	or 28a	Director	10e. Street and Number	,	24201	10f. Zip Code			10g. Citize	n of What Co	untry?	
	ath wi		1332 W. North A	venue		2121	7		U.S			_
·0	fter de r item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	10.S. 1	3. Was Decedent of F If Yes, specify Cub	fispanic Origin? (S an, Mexican, Puert	pecity Yes or No o Rican, etc.)	- 14	I. Race - Ame Black, White		
Baltimore, Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Madien Exeminat reset be redified at	by	3 😾 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □Yes 2√⊡√ No	Specify:		S	Specify: B]	.ack	
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p	be filectal Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Si	urname)		
Z	d Men narke	မ	Louis Nelson	- 7-i-0	1 405 14	W Add (Ot		ie Prid				
<u>⊠</u>	nd 2 shalth an 27 is r		19a. Informant's Name/Relationship (Type Kevin Nelson-So	,	1	ailing Address (Street				. = .	·	
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Ĕ	tment tment tant: I		1X Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	B	ethle	hem Bapt	ist12-6	-2008	St.	Steph	nens, S.C	•
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy highry or other traumatic event, I'm Microfie Exprinter reast be retilled at once.		21. Signature of Funeral Service Licensee	E-Yadd	-	22. Name and Addre		March l Avenue	East e Bal	F/H lto, N	1D 21202	
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8	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):							
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		Medi	IF FEMALE:									
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oj.	the de	hysic	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	9 Unknown	or uçalıı	3 □ Other (specify) _						
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ita	sician: The l certificate ha rector, page	Be Co	25. Was case referred to medical			-	26. Place of Dea	1 ☐ Yes		1 □Yes	2 □ No	_
Division of Vital Records,	Physical this ce al direc		ILI Tes ZIANO	spital: 1 Inpatient 2			4 LI Nursing H	ome 5 ☐ Resid	dence 6 [☐Other (Spec	cify)	
uc	ding Ph h. After th funeral	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year	28b. Time Injur	y Wor	yat k? Yes 2 ⊟No	28d. Describe h	now injury o	occurred		
/ISI	Attender death	ifical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm,		165 2 110	28f. Location (S	Street and i	Number or Ru	ral Route Number,	
á	tal or Atres after de al Direct	Certification: To	4 ☐ Homicide determined	building, etc. (Spe	эспу)			City or Tov	vn, State)			0
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, F.	Medical	29a. Certifier (Check only one) Check only one) Certifying Physic 2 Medical Examine	cian: To the best of my er: On the basis of exame and manner stated.	knowledge, de ination and/or	eath occurred at the ti	me, date and place opinion, death occu	e, and due to the rred at the time,	cause(s) a date and p	ind manner as lace, and due	stated. to the cause(s)	
	To the withing to the complex	Š	29b. Signature and title of certifier			29c. Licens				signed (Month		
	_		Hayman		00 \ T		81698	/	12	102/	2008	
	D		30. Name and address of person who com TEMILOLU AJE		tem 23a) (Typ	GREENE	57 B	ALTIM	ORE	MD	,21201	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 4 2008	32. Registrar's Sig	mature	SHE						

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 3866 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12:10 pm ROBERT WADDELL 29 2008 November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner FAYETTE HEALTH & REHAB CENTER BALTIMORE N/A If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Months Days Director APR. 24 1931 PENNSYLVANIA 214-26-4119 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "naturel", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examination 2000. 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1XXYes 2 □ No MARYLAND BALTIMORE N/A Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2405 W. LAFAYETTE AVENUE Funeral 21216 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 AYes 2 □ No If Yes, Give 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 ☐XNo Specify: δ 3 Widowed 4 Divorced 50/53 Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL-SUPPLY CLERK FEDERAL GOVERNMENT 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ WILLIAM WADDELL AMANDA JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY E. WADDELL/SISTER 7219 Park Heights Ave., Apt 404, Balto. Md. 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 12/9/08 OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Severe 10 Yust Examiner Due to (or as a consequence of) Physiclan/Medical Examiner requires that the death certificate be executed ete hes been signed by the attending physician and page 2 should be detached for use as the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate has 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 931865 12-2-08 KIZO 1000 241 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Baltinoro antow street 206 Rm 872 31. Date filed (Month, Day, Year) 32. Mgistrar's Signature State Registrar

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
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DHMH 17 Rev 1/2001

		For State Registrar		State of Ma	aryiano	•	artment of i rtificate of		i Mentai F	iygiene Reg. No.	2000	20662
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Funeral Director		5. Social Security N	6460	Sex 7. Ag	e (In yrs. Ia 66	st birthday) Yrs.	Months Days	If Under 24 Hr Hours Mir	8. Date of 1 (Month,	Day, Year)	l Co	thplace (State or Foreign ountry) NY
and		Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
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death	Funeral	11. Marital Status	ILU CC.	12. Was Decedent Armed Forces?	Ever in U.S.	. 13.	Was Decedent of I		(Specify Yes or	No- 1	14. Race - Ame	rican Indian,
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4		30. Name and add	ress of person wh	o completed cause of d	eath (Item 2		och Rau	2-121	Und 1	2 14	n_{i}	21218
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Day Year December 2, 2008 Physician Theresa Μ. Wilfer 8:45 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FutureCare-Chesapeake Arnorld Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) July2,1917 7. Age (In vrs. last birthday) **Funeral** 1 M 2 K Months Days Hours Min. 216-12-2498 91 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f show Md. Baltimore City Director 1 DXYes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 501 South Glover Street 21224 U.S.A Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, In-IM. Elementary/Secondary (0-12) College (1-4or 5+) 6th <u>Operator</u> Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Wilfer Martha Lang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Andrew Booz (nephew) 501 South Glover Street Baltimore, Md21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 12-5-2008 Baltimore, Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 21. Signature of Funeral Service License 1201 Dundalk Avenue Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PROBROVASCULAR 1 MONTH /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infiltrediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sunsequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s 24a. Was an autopsy performed certificate 2 XNo 1 ☐ Yes 2 ☐ No this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

To the within 2

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title-of certifier

Michael Alan Ankrom, M.D. 8601 VeteransHighway 32. Refistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 46360

29d, Date signed (Month, Day, Year)

December 3, 2008 Maryland 21108

Suite204, Millersville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 17, 2008 Day Edward Wesley Adams, Jr. 5:30 AM Voyember 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Point Perr VA Maryland Health Care System If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Sex 1X M 2□ F 8. Date of Birth (Month, Day, Year) Months Days Hours <u>039-22-2172</u> June30,1935 Rhode Island Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b, County 10d. Inside City Limits 1 XYes 2 No Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Bayview Avenue 21613 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 54 - 57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cleaning & College (1-4or 5+) Elementary/Secondary (0-12) Sales Manger Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Wesley Adams Grace Evelyn Doonan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Wesley Adams, III 307Emiley Lane, Severna Park, Maryland 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ST.Joseph Cemetery 11-21-08 WestGrennwich, R.I. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee michael ! margullo 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or comoverations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardionyapath **UUKUANU** disease or condition resulting in death) Due to (or as a consequence of): Portic Syste Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). tensian Due to (or as a consequence of): Diabetes Mellitus IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPice Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

/Medical **Examiner** sician and burial-transit Division of Vital Records, P.O. Box 68760 \mathcal{C} the attending pl funeral director, page 2 should certificate After t Hospital or Attending

24 hours after death.

Funeral Director: A filled in by the

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

Be Completed by

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?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exprises must be notified at

Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, II once.

Physician

Known To Physician:

Maryland

Baltimore,

Pages '

completely

Medical Certification: To within 2

State Registrar

4 Homicide

(Check only one)

29a. Certifier

Sher A. Hockmi, M.D.

29c. License number

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) November 17, 2008

Point, Maryland 21902

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VA Maryland Health Care System, Pery 32. Registrar's Signature

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

DEC 04 2008

08-08500

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Timothy Joseph Atkinson	State of Maryland / Department of Health

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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director:	Medical	29b. Signature and title of certifi	and manner state	<u>d</u>		29c. Licens		_					th, Day, Year)
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("		30. Name and address of person Theodore M. King, Jr				111 Penn St	reet, Ba	ltimore	e, MD 212	201			
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Baltimore, Maryland 21215-0036

burial-transit Box 68760. P.O. Division of Vital Records,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Nov. 2008 12:45 P M Mary Elizabeth Armfield /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Taney town Lorien Nursing Home 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ M Days Hours 217-18-1085 86 Director April 24, 1922 Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hyglene. n 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Mt. Airy Maryland Carroll Director 1 ☐ Yes 2 ☑ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21771-5456 United States 110 Fairview Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2√√No Specify: Specify: White 9 3√Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas A. Conaway Nettie Harrison ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Jane Haines 621 Meadow Branch Road Westminster, MD 21158 permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tr. once. daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Cify or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery Nov. 18, 2008 Mt. Airy, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory Funeral Service Licensee W. Old Liberty Road Winfield, MD 23a. Part / Enter the disease, or complications that shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. diate Cause (Final **Physician** burys disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed rusio Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 DYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours arter community to the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a, Certifier 1 🖒 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 21 WI 5 Name and address of person who completed cause of death (Item 23a) (Type, Print) Manchester 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

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The second of the cause (s) and manner as stated. 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one)	
and manner stated 29b. Signature and title of certifier 1BTE A KAZMI, MM 29c. License number 29d. Date signed (Month, Day, Year) 11-13-200 F	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) House - Frederica, My 2170/	
State Registrar NOV 1 8 200	
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Examiner	4a. Facility Name (If not institution, give street ar Saint Joseph Mec	d number) ical Center 4b. (City, Town, or Location of Death Towson	4c. County of Dea 日本	th Ltimore
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or 28a-f sh	MD. ANNE ARUN	XI GLEN	BURNIE		1 ☐ Yes 2 ▼ No
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Baltimore, permit. Pages 1 ar Department of Hes Important: If item any injury or othe	21. Signature of Fureral Service Licensee	22. Nam	e and Address of Facility	08 HANOVER, 1 Sherty Funder	HOME
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	IF FEMALE: 23c, If ve	s, outcome of pregnancy		23d. Date of de	livery
P.O. Box (and the death cert) and the death cert dby the attending letached for use a Physician/M	in the past 12 months?	Live birth 2 ☐ Fetal death 3 ☐ Ector Pregnant at time of death 5 ☐ Othe	pic pregnancy r (specify)	Month	Day Year
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The lay ate has bage 2				autopsy prior to death? 1 □ Yes 2 ☑No 1 □ Yes	completion of cause of
Vital Recidentician: The lavecertificate has ector, page 2:	25. Was case referred to medical examiner?		26. Place of Death (Ch		-A
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Division of Vital Reformers to the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, street, far building, etc. (Specify)	ctory, office 28f. I	ocation (Street and Number or R City or Town, State)	ural Route Number,
Dital cours af	29a. Certifier 1 Certifying Physician:	To the best of my knowledge, death occu	rred at the time, date and place, and	due to the cause(s) and manner a	e stated
o the Hosp ithin 24 hou o the Fune ompletely fil	(Check only 2 Medical Examiner: On	the basis of examination and/or investige manner stated.	ation, in my opinion, death occurred a	t the time, date and place, and du	e to the cause(s)
To the within comp	29b. Signature and title of certifier		29c. License number	29d. Date signed (Mon.	th, Day, Year)
	Ann	5)	D37254	1119	108
<u></u> り	30. Name and address of person who completed BOON POH LIM M. D.	cause of death (Item 23a) (Type, Print) 7601 OSLER DRIV	IE TOWONE MAD	/LOND 01004	
State		32. Registrar's Signature	(FINDOM MHIL)	FULL TO THE TOTAL	
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DHMH 17 Rev 1/2001		ORIGINA	L		

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Ε. 2008 11:07 PM Minnie Bymun 15, /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2402 Brooks Drive Suitland Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 246-52-1047 1 □ M 2 🗓 F 73 Director June 26, 1935 North Carolina Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Wedical Examinar must be notified at Director 1 XYes 2 □ No Maryland | Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2402 Brooks Drive 20746 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married "natural", or altimore, Maryland 21215-0036 1 □Yes 2 🛣No Specify: Specify: Black <u>\$</u> 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 years College (1-4or 5+) Waitress Government Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, II once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aaron Snead Sadie M. Hill ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Smith - Daughter 2402 Brooks Drive Suitland, MD 20746 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery Nov. 21, 2008 Washington, DC 21. Signature of Euneral Selvice License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Heart Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dee to (or as a sonsequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s After this certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ado va 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State NOV 2 1 2008 Registrar

DHMH 17 Rev 1/2001

08-08627 Melvin Bailev

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

vierviii Dalley	1- For State Registrar Reg. No. 2 1 1 8 3 8 6	7
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
E	7933 Johnson Avenue # 912 Hyattsville Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or	_
Funeral Director	214-86-1523 1X M 2 F 37 Yrs. Months Days Hours Min. 12/23/1970 Foreign MARYLAND Country)	
au kur	Usual Residence of Decedent 10a. State	5
Aaryland Aaryland Lat once.	1 X Yes 2 No)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho r other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
ms 23a be noti	7933 JOHNSON AVE # 912 20706 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,	
er death with , or items 23 r must be no Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 XDivorced If Yes, Give Year 1 Yes 2 X No specify: Specify: BI,ACK	
atural ramine	Of Dates	
5-0036 ed within 72 hour tygiene. tygiene "natu matu ihe Medical Exar	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	
5-00; led with tygiene other t	12TH MACHINCE OPERATOR PRIVATE 17. Father's Name (First, Middle, Last) - 18. Mother's Name (First, Middle, Maiden Surname)	_
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours af nt of Health and Mental Hygiene. It: If lien 27 is marked other than "natural other traumatic event, the Medical Examin To Be Completed by	SAMUEL BAILEY JOYCELYN HALL	_
MD 21 d 2 should d 2 should lith and Me n 27 is ma aumatic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCELYN D. STEPHENS/ MOTHER 7933 JOHNSON AVE. #912 GLENARDEN, MD 20706	П
more, MD Pages I and 2 sho ent of Health and nt: If item 27 is rother traumati	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)	_
Baltimore, Pages I ar permit, Pages I ar Department of Her Important: If iten injury or other tr	4 Donation 5 Other Specify, RESURRECTION CEMETERY 11/25/08 CLINION, MD	
Baltir permit. Departme Importar injury or	21. Short ture of Furneral Service Licentee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD. LANDOVER, MD 20785	
Physician	23a. Part I. Enter the disease, or complications that caused the death: Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval	
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	
	Sequentially list conditions, b	
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5876 prtificate ding phy e as the an/M	FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year	
). Box 687 the death certific by the attending p ched for use as th	4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
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Di ospital hours a meral I y filled	4 Homicide determined (Specify)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attenting Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attenting physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transs Medical Certification: To Be Completed by Physician/Medical E.	Check only Check only Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	ı,
We is a set of the se	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	30. Name and address of person who completed cause of leath (Item 23a)	
De	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	K
	31. Date (Jed (Maath, 2008ar) 32. Registrar's Sign (ure	\neg

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death NOVEMBER 13 2008 Larry T. Bailey, Sr. 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Burnie BAHIMORE Washington Medical Center ANNE Glen ARUN DE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. 02/11/1950 Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) Months 1 🕅 M 2 🗆 F 217-56-4521 58 Tennessee Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2XINo Maryland Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 Greenland Beach Road 21122 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No 1982-Specify: White 3 ☐ Widowed 4 ☐ Divorced 1988 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Edward Bailey Elvie Mae Burton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela A. Bailey/Wife <u> 1715 Jefferson Highway, Jefferson, LA 70121</u> 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 3 □ Other (Specify) 11/16/2008 Edgewater, Maryland Kalas Crematory 21. Signature of F 22. Name and Address of Facility George P. Kalas Funeral Home la 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANONI IN CUPHAWPAIN Due to (or as a consequence of): Acui Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

The law requires that the death certificate be executed and burial-Box 68760. the attending physician the as nse or P.O. signed by the a Division of Vital Records. has been this certificate Hospital or Attending Physician: After To the Hospina. ... within 24 hours after death.
To the Funeral Director: After anneletely filled in by the fur

Physician

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examinat must be retiffed at

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other that any Injury or other trainmant.

Physician

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Physician/Medical

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Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

30. Name and address of person

Maryland 21215-0036

Baltimore.

State Registrar

BALDMORE 31. Date filed (Month, Day, Year) NOV 1 7 2008

who completed cause of death (Item 23a) (Type, Print) WASHITEIDA 32. Registrar's Signature

and manner stated.

29c. License number

Tsion Berhane

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOV. 0830 6, 200 g Μ. Bounds Pauline 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Salisbur Wicomico Rehab & Nursing Ctr. lisbury if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 ☐ M 2 🗓 F Months Days Hours Min Yrs. 3-1-1928 80 |222-16-5742 Delaware Usual Residence of Decedent 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Delmar MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 29395 Connelly Mill Road 21875 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 Kearney Court, Salisbury, Maryland 21804 Lynda Lane - Personnel Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarvall-18-2008 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service L E. Main Street, Salisbury, Maryland 21804 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of ach line. Immediate Cause (Final disease or condition resulting in death) 7000 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DAT ue to (or as a mesequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 wursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be nent of Health and Mental

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed

or Vital Records, P.O. Box 68760.

Examiner attending physician and for use as the burial-tran Physician/Medical been signed by the should be detached ð Completed Be 2 Certification:

27. Manner of Death

1 Hatural

2 Accident

3 ☐ Suicide

29a Certifier

4 ☐ Homicide

has

certificate

this

Physician:

neral Director; After the filled in by the funeral or Attending Hospital 24 hours a within 2 To the

> State Registrar

Medical

29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200

and manner stated.

28a. Date of Injury

(Month, Day Year)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Robins, W.D 31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 ☐ Could not be

NOV 1

determined

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

stifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** BAILEY 2008 Nov 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PENINSULA REGIONAL SAlisbury If Under 1 Year If Under 24 Hrs. Wicomico CENTER Medical 6. Sex 1 M 2 □ F Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Months 5-28-1957 Maryland Director 220-68-8001 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 28a-f show nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Eventine must be notified at **Funeral Director** Salisburg licomic 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) pment Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (ပ 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbary Jones Jawn h. Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State permit. Pages Department o Important: If I 7-08 remotion! Dover Signature of Fundar Service Licensee 22. Name and Address of Facility W. Isabella Street omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part I. Exter the disease, or shock, or heart failure. List Immediate Cause (Final **Physician** INFORCTION Wicoldings disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Drangle 170cm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

or Attending Physician: The law requires that the death certificate be executed for use as detached director, page 2 should be

P.O. Box 68760,

Division of Vital Records.

funeral

filled in by

completely

After

death.

within 24 hours after death To the Funeral Director:

Hospital

Physician/Medical Examiner Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed Be (25. Was case referred to medical examiner? Medical Certification: To 27. Manner of Death

IF FEMALE:	
23b. Was decedent pregnant in the past 12 months?	
1 ☐ Yes 2 ☐ No	
9 ☐ Unknown	_

1 Yes 2 No

1 Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

220 If 1	100 0	itcomo	of	pregnancy
1 [7 1 ive	hirth	2 [☐ Fetal de

D1540515

Date of Injury (Month, Day, Year)

Liver

Fulled or dong

4 ☐ Pregnant at time of death 9 Unknown

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Due to (or as a consequence of):

1	3 ☐ Ectopic pregnancy
	5 Other (specify)

Month Day

23e. Did tobac	co use con	tribute to the cau	use of death?
1 ☐ Yes	2 🗌 No	3 ☐ Probably	4 🗗 Unknow

23d. Date of delivery

24a. Was	an
auto	psy
perfo	ormed?
1 ☐ Yes	2 🗷 🗖

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

3. Time of Death

0640

10d. Inside City Limits

Black

1 Yes 2 No

21801 Approximate Interval Between Onset and Death

Year

26. Place of Dea	th (Check only one)
Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
njury at Vork? I □Yes 2 □No	28d. Describe how injury occurred
ce	28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Numb City or Town, State)
	cian: To the best of my knowledge, death occurred at the time, date and place er: On the basis of examination and/or investigation, in my opinion, death occu	

28c.

٠	Signature	and	title	or cer	tifier			
	1 4	-	_		0			
	Mar	0	0	W.	1	alle	m	

5 Pending investigation

6 Could not be determined

29c. License number 27527 29d. Date signed (Month, Day, Year)

		n n	4 0.0
30 Name and address of person who completed cause of death (Item 23a) (Type Kickoro it Schlasting)	P.O. Box 2018 Salesban	is and.	21802-2018
31. Date filed (Month, Day, Year) NOV 1 8 2008 32. Refistrar's Signature	Land,	/	

28b. Time of Injury

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 U U O Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 4:40PM Gregory Eldon Barry 22200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington

9. Birthplace (State or Foreign Country) Washington County Hospital
5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) Hagerstown If Under Year If Unde 8. Date of Birth (Month, Day, **Funeral** Year) Davs Min. Months Hours Director September 15,1953 CA 545-98-1785 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examinat must be notified at 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location 1 □Yes 2 ▼No Director Fulton PA Mercersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17236 USA Funeral 1544 West Orchard Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 9 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eldon Barry Myra Staley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 164 Warfordsburg, PA Carol J. Barry/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/28/2008 Indiana. PA Oakland Cemetery 22. Name and Address of Facility 141 West Main Street 21. gn dure of Funeral Service Licensee Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician سعام disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Every group of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? Month Day Ye ar 1 ☐ Yes 2 ☐ No been signed by the should be detached Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1. Yes To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

111

32. Registrar's Signature

31. Date filed (Month, Day, Year)

DEC 0 4 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38676 Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Mary Dolores Bullard 11 21 2008 740 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year Dec 30, 1933 9. Birthplace (State or Foreign Birthpie (Country) Months Days Hours Min. 1 □ M 2 □ ¥ 060-28-3235 74 Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 ¥Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 611 N. Centre Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Baer Dolores (Knaggs) Baer 19a. Informant's Name/Relationship (Type. Print) Karen Repp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 N. Centre Street Cumberland MD 21502 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Scarpelli Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/25/2008 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Line 22. Name and Address of Farileral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Adenocurcinoma 2 months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2X No 1 ☐ Yes 2 X No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

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After t

law requires that the death certificate be executed

To the Hospital or Attending Physician: The

death.

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be retified at

72 hours after

d 2 should be filed with and Mental Hygier 7 Is marked other the

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any Injury or other traun once.

Baltimore, Maryland 21215-0036

Examine burial-transi attending physician for use as the burial Physician/Medical signed by t ð ns certificate has been s director, page 2 should I Completed Be funeral within 24 hours after deatl To the Funeral Director: filled in by the

Certification: To

Medical

1 Yes 2√2 No 27. Manner of Death Natural
Accident

29a. Certifier

(Check only

3 Suicide 4 Homicide

29b. Signature and title of certifier

5 ☐ Pending investigation 6 Could not be determined

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of Injury (Month, Day, Year)

28c. Injury at Work?

1 □Yes 2 □ No

D0055325

Nov 21, 2008

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 BISHOP WALSH RD Cumberland MD21502 WONSOCK

State Registrar

completely

31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 03 2008

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 12:58 PM Kenneth W. Blevins November 28 2008 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Harford Havre de Grace
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 7, 1936 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Days 1 ☑ M 2 □ F 218-32-6622 72 Virgínia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Director MD Cecil Rising Sun 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21911 114 Woody Brown Road U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White ٥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Prison 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earnest Blevins Ella Sawyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Blevins (Spouse) 114 Woody Brown Rd. Rising Sun, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Rock Run Cemetery 12/2/08 Havre de Grace, MD 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.

Aberdeen, Maryland 21001-3399 Depart Depart Import any inj 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on eath line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 EP/Outpatient 3 DOA ၉ 1 🗌 Yes 27. Manner of Ceath ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completely filled in by to 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of 29c. License number 40 tem 23a) (Type, Print) ALRYOND MEMORIAL HOSPITAL, JOI SOUTH UNION AVENUE, HAVRE DE CRICE 21078 Registrar

08-08793 Tra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

Travis T. Burgette	1-1	For State	State	of Maryland		ment of He ficate of De		Mental Hyg	Reg. 1	yo. 20	08 3867
Physician/	1.		e (First, Middle,La					. 2	Date of Death Month Da November 23		3. Time of Death 1309 hrs
Medical Examine	r		Troy Burget	te ve street and number	or)	4h (City, Town, or Lo	ocation of Death	November 23	4c. County of Deat	
1	48	a. Facility Name (Union Hosp		ve street and number	61)		lkton			Cecil	
Funeral Director	5.	Social Security 1 168-64	1000	Sex' 7	Age (In yrs. last		Under 1 Year Months Days	If Under 24Hrs. Hours Min.		y 31, 1971	rthplace (State or gn puntry) PA
any.	_	Isual Residence o	f Decedent 10b. County		10c. City, To	own or Location					10d. Inside City Limits
CK		MD	Cecil		E	Elkton					1 Yes 2 No
(322) (in the Maryland s 23a or 28a-f show enoithed at once.	1	0e. Street and Nu 2880 C	Old Elk Ne	ck Rd.			of, Zip Code 21921			Citizen of What Co	
Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unt. If item 27 is mayed other than "matural", or items 23a or 28a-f she other transmatic event, the Medical Examiner must be notified at once and the American Medical Examiner must be notified at once and the American Medical Examiner must be notified at once and the American Medical Examiner must be notified at once and the American Medical Examiner must be notified at once and the American Medical Examiner must be notified at once and the American Medical Examiner	חובום ו		ied 2 Marrie	12. Was Deced Armed Forc 1 Yes ed If Yes, Give Year		If Yes,	specify Cuban, es 2 No	panic Origin? (Spe Mexican, Puerto F specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black, Black
urs afte	<u>-</u>	3 Widowed 15. Decedent's E		only highest grade	completed)	16a Decedent's	Usual Occupati	on (Give kind of we		6b. Kind of Business	/Industry
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Baltimore, MD 21215-0036 permit: Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: Iftem 27 is mayked other than injury or other traumatic event, the Medical	8	Carl B	e (First, Middle, La Irgette, Sr.						McCloe		to Zin Code)
2121: thould be fill and Mental I is marked attic event,	0 7		lame/Relationship a Braywood			1		and Number or R Neck Rd., I		er, City or Town, Sta	ite, Zip Code)
mand 2 sho lealth and tem 27 is traumati	+	20a. Method of D	sposition		1 -	lace of Disposition	on (Name of cer			20c. Location - City	or Town, State
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Baltimore, permit. Pages 1 at Department of He Importants. If it injury or other tr	1	21. Ignature	Priera Service Lie	censee		A	ne and Address	Gee Funeral	Home, 259	E. Main St.,	Elkton, MD 21921
Physician	+	23a. Part I. Enter	the disease, or co	mplications that cau	used the death.	Do not enter the	mode of dying,	such as cardiac or	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
*Medical aminer		Immediate Cause or condition resu		a. <u>Hydro</u> Due to (or as a c	morphon consequence of	<u>ie intox</u>	<u>ication</u>				
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i, P.O. Be ires that the de signed by the dedeached f	by Phy	Part II. Other si	gnificant condition			esulting in the ur	nderlying cause	given in Part I.			e to the cause of death? Probably 4 Unknown
Division of Vital Records, Fala or Attending Physician: The law requires rs after death. al Director: After this certificate has been sign led in by the fineral director, page 2 should be	Completed								24a. Was a autop perfor	sy prior med? deat	e autopsy findings available to completion of cause of h? Yes 2 No
ital Recorician: The law i		25. Was case re	eferred to medical				26.Plac	ce of Death (Check			
Vita ysician this cer direct	o Be	examiner?	_ 2 No	Hospital: 1 🗸 1	npatient 2	ER/Outpatient					Other:
n of Vital Rec ding Physician: The I h. After this certificate I is funeral director, page	on: T	27. Manner of D	eath 5 Pendi	28a. Date (Month		28b. Time of Ir		ury at Work? Yes 2X No	unk	how injury occurred	
Division pital or Attene ours after death teral Director:	ertification:	2 Accider 3 Suicide	t Invest	igation FD 1	e of Injury - At h	FD 11:5 nome, farm, stree a1 room	t. factory, office	building, etc.	28f. Location (Sor Town, Sor Elkton	Street and Number of State Union H	or Rural Route Number, City OSPITAL
Divisior To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	O	4 Homicie 29a. Certifier (Check only one)	de	ysician: To the bes	st of my knowled of examination	dee death occur	red at the time	date and place, an	nd due to the caus	se(s) and manner as and place, and due	stated. to the cause(s)
To tl withi To tl	Medical		and title of certifie	and manner s	stated.			nse number			(Month, Day, Year)
		1/1	Um B	anell.	MA	m 23a\	0.0	C.M.E.		November 24	ł, 2008
		/	address of person Brassell, MD	who completed cau Assistant Me			enn Street,	Baltimore, MI	21201		
St Regist	tate	31. Date filed (I	DEC 0 4	2008	égistrar's Signa	ture Agg	R				

			For State	State o	of Mary	land / Dep				and Me	ental Hy	giene)			
			Registrar 1. Decedent's Name (First, Middle, Last)					rtificate of Death				Reg. No. 2 3 Time of Death				
	Physicia	an						2. Date of D Month				Day		ear		
	/Medic		William Frank Crayle, Sr.				1 45 City	4b. City, Town, or Location of Death				Nov. 19, 2008 4c. County of Death			8:15	ΑM
	Examin	er	4a. Facility Name (If not institution, give street and number)						_	Ji Death			•			
		-19	5203 Upshur Str	eet 5. Sex	7 Age (In	yrs. last birthda		dens	burg If Under	24 Hrs.	8. Date of Bir				orge s	
	Funeral Director		579-46-6075	1⊠M 2□F	7	-	Months	Days	Hours	Min.	(Month, Da July 3	ıy, Year)		Coun	ensbur	
		ii	Usual Residence of Decedent								July J	, 17	ט וכ	Tau	SHEDUL	g, MD
	yland now at		10a. State 10b. County		100	c. City, Town or	ocation							1	0d. Inside Ci	ity Limits
	Mar a-f st ified	ţċ	Maryland Prince	George's	В	ladensb	ırg								1 X Yes	2 □ No
	or 28	Directo	10e. Street and Number				10f. Zip	Code				10g. Citi	izen of Wh	at Cour	itry?	
	th wi	je	5203 Upshur Str	eet			207	10				USA				
	r dea	Funeral	11. Marital Status	12. Was Dec Armed F	orces?	in U.S. 13	. Was Dece If Yes, spe	dent of Hi	ispanic Ori ın, Mexicar	gin? (Spec	cify Yes or No Rican, etc.))-	14. Race - Black,	Americ White,		
õ	be filed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 Marrie	d 1 ∑Yes If Yes, G	2 □ No live Dates: 195	E 10E7	1 ☐ Yes	2⊠ No	Specify:				Specify:	Mh	ite	
2-002p	hours ural"		3 Widowed 4 Divorced		Dates: 190		edent's Usu	al Occurs	ation			16h K				
ς C	"nat	Completed	15. Decedent's (Specify only highest)	(Gi	e kind of wo	ork done d se retired	during mos	t of workin	g	TOD. KI	ind of Busi	iess/inc	Justry	
7	withii ene. than he M	ğ	Elementary/Secondary (0-12)	College ((1-4or 5+)		il Bur					He	ating	/AC		
D	filed Hygi sther ent, t	ပို	17. Father's Name (First, Middle, L.	ast)							(First, Middle			, 210		
апа	ld be ental ked c	To Be	Gerald Crayle						Virg	inia	Alma (Owen:	s			
3	shou nd M mar	-	19a. Informant's Name/Relationshi	p (Type. Print)		19b. Ma	ling Address	(Street a			Route Numb			ate, Zip	Code)	
<u> </u>	nd 2 allth a 27 Is r trau		Donna Lee Marie	Crayle	/ Wif	e 5203	Upsh	ur Si	treet	, Bla	idensbu	ırg.	MD 20	0710)	
ē,	of Hei		20a. Method of Disposition		2	0b. Place of Dis	position (Na	me of other plac	e) !	Da	ate	20c. Lo	ocation - Ci	ty or To	wn, State	
Ē	Page lent c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		i State I	Fort Li	-			11/23	3/2008	Brei	ntwoo	d. N	larvla	nd
Баштог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Europeal Service L	iconsee /			22. Name a								nore A	
מ	o a m c		films	11	>		asch'	s Fu	neral	Home	P.A.	Hya	attsv:	111ϵ	MD	20781
			28a Part1. Enter the disease, or shock, or heart failure. List o	omplications that nly one cause on	caused the each line.	death. Do not e	nter the mo	de of dyin	g, such as	cardiac or	respiratory a	rrest,			Approximat Interval Bet	te tween
	Physician		Immediate Cause (Final disease or condition Malignant Neoplasm: Main Bronchus								Onset and I	Death				
<i>†</i>	/Medical Examiner		resulting in death) Due to (or as a consequence of):													
	Examiner	_	Sequentially list conditions.													
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
	and all-trar	xan	that initiated events resulting in death) Last			entia,	Jncomp	llca	tea					-		
2/00	certificate be executed iding physician and ise as the burial-transit	E E		L .		,										
200	ficate phys	edical	323	d												
XOD	nding use a	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou									23d. Date	of delive	ery	
Ď	death e atten	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	nant at time		□Ectopic p □ Other (s						Month	1	Day	Year
5	t the	Physician/M	9 Unknown	9□Unkr	nown						1					
,	requires that the death certific een signed by the attending p hould be detached for use as	by P	Part II. Other significant condition	s contributing to	death but no	t resulting in the	underlying	ause give	en in Part I		23e. Did t	obacco u	use contrib	ute to th	ne cause of d	death?
cords	w require been sign										1 🗆	Yes 2	⊠ No 3	☐ Prob	bably 4 □U	Unknown
ပ္ပ	law as b	Completed									24a. Was		24b. We	ere auto	psy findings mpletion of c	available
r	sician: The law certificate has b irector, page 2 s	P P									perfo 1∐ Yes	rmed? 2 ☑ No	dea	ath?	2 No	
VII	clan: ertific	Be (25. Was case referred to medical examiner?							of Death	(Check only o	опе)				
0	hyslathis c	ို	1 ☐ Yes 2 🔀 No			2 ER/Outpat			4 🗆 NU		ne 5⊠Resi				y)	
	After Uner	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		e of Injury nth, Day Ye	ar) 28b. Time Injun		28c. Injun Worl		{	8d. Describe	how injur	ry occurred			
2	ttenc death stor: / the	icat	2 Accident investiga 3 Suicide 6 Could no	ot be 200 Place	e of injury -	At home farm	M treet factor		Yes 2□		8f Location /	Stroot or	od Numbor	or Pum	d Pouto Mun	nho.r
28d. Describe how injury occurs 28d. Describe how injury 28d. Describe how injury 28d. Describe how							e)	mber or Rural Route Number,								
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ledical C	(Check only 2 Medical E	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										s)		
	o the ithin 2 o the orple	Med	one) 29b. Signature and title of certifier	and ma	nner stated.		29	c. License	e number			29d. Da	te signed (Month.	Day, Year)	
Had Is as						(06-6-	6605			29d. Date signed (<i>Month, Day, Year</i>) 11/19/2008						
	511		39. Name and soldress of person w	ho completed car	use of death	(Item 23a) (Tvn	e, Print)	e w	V (Q)							
	7 /		L.R. DOMA LES	KUSKI	920	O BAS	1/ 00	urt	#21	n K	ALGO	MI	20	70	12/	
	Sta		31. Date filed (Month, Day, Year) NOV 2 1 2008	32.	Registrar's	Signature					- 1				-	
	Registr	ar	100 F W T 7000	The Season	Z K	Consel	1									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Cei	rtificate of	Death	Reg. N	2008	3868U				
ı	Physic	ian	1. Decedent's Name (First, Middle, Last) Joan Marie Counte	0		2.		ay Year	3. Time of Death				
200	/Medi Exami		4a. Facility Name (If not institution, give street and number)	е	4h. City. Town.	or Location of Death	Jovember	c. County of Death	8:40 PM				
-	LABIIII	iei	Doctor's Hospital		Lanham			ince Ge	orges				
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 5 Usual Residence of Decedent 7. Age 5	(In yrs. last birthday) 1 Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Year	9. Birthp Coun 957 Mary	lace (State or Foreign try) 1 a n d				
	Maryland a-f show	ctor	MD 10a. State Prince Georges	10c. City, Town or Lo Bowie	cation			10	0d. Inside City Limits 1 ∰Yes 2 ☐ No				
	th with the 23a or 28	ral Director	10e. Street and Number 2400 Artesian Lane		10f. Zip Code 20716		USA	Citizen of What Count	try?				
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madicel Examinar must be rediffied at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Ye ar or Dates:	o I	Vas Decedent of I fYes, specify Cub ☐Yes 21 No	Hispanic Origin? (Specifian, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - America Black, White, e Specify: Bla	tc.				
21215-0036		Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 + College (1-4or 5+	(Givo	lent's Usual Occup kind of work done OO NOT use retire tive Ad	pation during most of working d) Ministrat		Kind of Business/Ind					
Maryland	ould be filed a Mental Hygin arked other atic event, It	To Be (17. Father's Name (First, Middle, Last) John Henry Countee			18. Mother's Name (F Virgie E			1				
, Mar	permit. Pages 1 and 2 sho Department of Health and I Important: If Item 27 is ma any injury or other trauma once.		19a. Informant's Name/Relationship (Type. Print) Erica Johnson / Daughte	r 3739	O St.	and Number or Rural R SE Washin	oute Number, City 19ton, I	or Town, State, Zip					
Baltimore,			20a. Method of Disposition 1 23 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem Fort Lin				ocation - City or Tov 1 a den s b u	•				
Bal	permii Depar Impor any in		21. Signature of Funeral Service Licensee	Du		5635 Eads		2 E Washin	0019 gton,DC				
	Physician /Medical Examiner	<u>.</u>	23a. Part 1. Enter the disease, or complications that caused to spock, or heart failure. List only one cause on each line Imme late Cause (Final disease or condition resulting in death) Due to (or as a Sequentially list conditions,	he death. Do not enter. He h' C consequence of):	ir the mode of dying 13 reas	ng, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death				
68760,	ding Physiclan. The law requires that the death certificate be executed n. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the buriat-transit	dical Examiner	dical Examine	Medical Examine	dical Examine	dical Examine	C. Due to (or as a customer line) and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a customer line) and the cause of	fa Sur'c consequence of): fecile	. Al	idos s			
^		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of the post 12 months? 1 ☐ Live birth 2 4 ☐ Pregnant at the post 12 months?	□ Fetal death 3 □	Ectopic pregnanc Other (specify) _	у		23d. Date of deliver Month E	y Day Year				
ords, l	equires that en signed ould be de	Completed by	þ	ğ	Part II. Other significant conditions contributing to death but	not resulting in the und	derlying cause giv	en in Part I.		use contribute to the ☑No 3☐ Proba	cause of death?		
tal Reco	To the Hospital or Attending Physiclan: The law requires that the death within 24 hours after death. In the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for use the form of the funeral director.		- If YPO fen Scim 25. Was case referred to medical				24a. Was an autopsy performed?- 1 □ Yes 2 ☑ No	prior to com death?	sy findings available pletion of cause of				
Ž	lysicla lis cert directo	o Be	examiner? 1 Yes 2 No Hospital: Inpatient	2 ER/Outpatient	3 □ DOA Oth	26. Place of Death (Cler: 4 □ Nursing Home		€ □Other (Co)					
Division of Vital Records,	or Attending Pn after death. Director: After th in by the funeral.	Certification: To	27. Manner of Death 1	28b. Time of Injury	28c. Injur Work M 1 🗆	y at 28d. ?? Yes 2 □ No 28f.	Describe how inju	ry occurred	Route Number,				
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical Cer	29a. Certifier (Check only one) Certifying Physician: To the best of	xamination and/or inve	occurred at the tir	ne date and place and	due to the cause/s	and manner as steel	ted.				
	Vithin 2 Vithin 2 Vomple	Med	one) and manner state 29b. Signature and title of certifier	d.	29c. License			ite signed (Month, Da					
	->-0		I fesio premi		D65			120108	*				
R	12		30. Name and address of person who completed cause of dea		rint)	ad Lanh							
	Sta Registra	_	NOV 2 1 2008	Signature		Le 13/1	W. 11. C	20101					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Month **Physician** 10:12 A^M 13. 2008 November G. Coleman Coleman /Medical Thomas 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 ★M 2 F Min. Months Days Hours 230-84-1107 54 Director Jan 27, 1954 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f shovevent, the "dedical Examinat must be notified at 1 Tyes 2 □ No Director Maryland Anne Arundel Harwood the f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3675 Solomons Island Road 20776 United States r death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 录No Specify Specify: **Black** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If fren 27 is marked other than "na any injury or other traumatic event and once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nolan Coleman Elise Barksdale ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Catherine McFadden - Sister 2205 Roslyn Avenue District Heights, MD 20747 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee's Crematory Nov. 22, 2008 Clinton, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signiture of Funeral Service Lice Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Cancer of Lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ 1 ▼ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has trector, page 2 s autopsy performed? 1 ☐ Yes 2 🖸 No 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice Be Hospital: 1 Tyes 2 No Other: 4 Nursing Home 5 Residence (Specify) House 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D21438 November 20, 2008

CR 3

31. Date filed (Month, Day, Year) NOV 2 1 2008

Michael J. LaPenta,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar
DHMH 17 Rev 1/2001

445 Defense Highway Annapolis, MD 21401

08-08788 Iris Chapman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

o onapman		- For State	Jiaic 0	i Maryiana i D	Certific	ate of	Death			Reg.	No.	200	9	3868
Physicia	n/	tegistrar 1. Decedent's Name (First, M	ddle,Last)							ate of Death onth D ovember 2	ay	Year		e of Death 45 hrs
ledical Examin		IRIS		CHAP	PMAN					ovember 2		nty of Death		40 1118
		4a. Facility Name (if not instit		street and number)		4	b. City, Town, Laurel	or Location o	or Death			ce George		
		Laurel Regional Ho		7 000 (10	Look bir	th day)	If Under 1-Y	ear If Inde	er 24Hrs. 8.	Date of Birth/				(State or
Funeral Director		5. Social Security Number 578-70-3769		7. Age (in	n yrs. last bii	Yrs.	Months D	ays Hours	Min. M	AY 15	1952		gn WA ountry)	(State of SHINGTON DC
any.		Usual Residence of Deceder 10a. State 10b. Cou		100	c. City, Town	n or Locati	on			1.9			10d. ir	nside City Limits
2 .			*	EORGE'S	Τ.ΔΤ	JREL							1 X	Yes 2 No
th the Maryland 23a or 28a-f show	Director	MD PRI	NCE GI	TOKGE 5	13770		10f. Zip Code	e		10g	. Citizen o	of What Cou	intry?	
or 28a-	Ĭ.										USA			
23a th	읊	8114 GORMAN	AVEN	<u>JE # 142</u> 12. Was Decedent Eve	er in U.S.	13. Wa	207 s Decedent of		oin? (Specify	Yes or No-		Race - Amer	rican Inc	lian, Black,
ath w items	Funeral		Married	Armed Forces?		If Y	es, specify Cu	ban, Mexican	, Puerto Rica	in, etc.)	'	White, etc.		
after death with the Maryland all", or items 23a or 28a-fehr iner must be notified at once		3 X Widowed 4	Divorced	1 Yes 2 X f Yes, Give Yeer	No	1	Yes 2X	No specify:			Spe	cify: BL	ACK-	
urs af turial	함	15. Decedent's Education (or Dates:	eted) 16a		t's Usual Occu			done 1	6b. Kind	of Business	/Industry	4
n "na	황	Elementary/Secondary (0-	12)	College (1-4 or 5+)			ost of working	life. DO NO I	use retired)		PRT	VATE		
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examin	Completed	12TH				HOME	MAKER							
21215-0036 utid be filed within 7 Mental Hygiene, marked other than ic event, the Medica		17. Father's Name (First, Mic	Idle, Last)							st, Middle, Ma		name)	-	
121 be fi ental errked vent,	Be	JAMES WILLIA	M SUG	GS		Ob. Mailine	A ddana (0		CILLE	COSE		Town Stat	o Zin C	ode)
Should Marice	2	19a. Informant's Name/Relat LANCE SUGGS/		pe, Print)	1	96. Mailing 8114	GORMAN	AVENU	E # 14	2 LAU	REL,	MARYL	ÄŃĎ	20707
ore, MD 2 es I and 2 shou of Health and P If item 27 is r her traumatic	\perp	20a. Method of Disposition			20b. Place	of Dispos	ition (Name of	cemetery.	Da	ite	20c. Loca	ition - City o	r Town,	State
Baltimore, Pages 1 ar Department of Hee Important frite		1 X Burial 2 Crem	ation 3	Removal from State	crem	atory or otl	her place)		10//		CLIN	mon M	4 D 3/T	A MTD
Fag Pag	4	4 Bonation 5 Othe	r Specify:		RESU		ION CE		12/4/	B. JEN	ULIN	FINE	RAT.	HOME
Baltimo Page Department of Important injury or other		21. Signat e neral Ser	vi⇒ L∠ens	ee			474 LA							
		23a. Part I. Enter the dise	e, or compli	cations that caused the	e death. Do								App	roximate Interval
Physician 'Medical		failure. List only one ca	ause on eac	h line.				**					Bet	ween Onset and Death
kaminer		Immediate Cause (Final disc or condition resulting in dea		Complication to the consequence of the consequence		<u>ura</u>	beles i	петтте	us					
	ı	One we stight list conditions	b.	20 (0) 20 2 2 3 3 3 3 3	,								1_	
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca		ue to (or as a consequ	ence of):									
	Examine	(Disease or injury that initial events resulting in death) L	ed c.	ue to (or as a consequ	uence of):		-						+-	_
kecuted n and - transit		events resulting in death) L	d.						1466					
exection and an and all all and an	Medical	X UNPENDED		AMENDED 23a,	27 , pe	cmE,	g886 1	2/15/0	8 TT					
760, cate be ex physician he burial	Med	IF FEMALE:	_	23c. If yes, outcome	of pregnance	у					23d. D	ate of delive	ery	
687 ertific ding p	au/	23b. Was decedent pregnant past 12 months?	in the	1 Live birth	no of dooth		etal death	3 Ectop	ic pregnancy		Mo	nth	Day	Year
Box 687 e death certific the attending p	sici	1 Yes 2 No 9 🗸	Unknown	Pregnant at tim	ne or death	5 O	ther (Specify)				1			
cords, P.O. Box 68' Iaw requires that the death certificate has been signed by the attending 2 should be detached for use as	Physician/	Part II. Other significant co	nditions	contributing to death b	ut not result	ting in the	underlying cau	ıse given in F	Part I.	23e. Did tot	acco use	contribute t	to the ca	use of death?
P.C s that gned t		•								1 Yes	2 N	o 3 Pr	obably	4 🗸 Unknown
ds, and b and b	Completed by									24a. Was a				findings available
Orcanor law re has be 2 sho	힐									autops perforr	ned?	death?	?	etion of cause of
Rec The icate	5							(5.1	101	1 ✓ Yes 2	No	1 🗸	Yes	2 No
tal cian: certif	Be	25. Was case referred to me examiner?		ospital: Innatient	- [d = p	10		Other	h (Check only		Residence	e 6 Oth		
of Vital Recoling Physician: The law After this certificate has been director, page 2 si	ဥ	1 ✓ Yes 2 No 27. Manner of Death		28a. Date of Injury	2 ✓ ER	b. Time of		Injury at Wo	Nursing H	d. Describe h			ici.	
n o ding	on:	1 V No.	Pending	(Month, Day,Year	r) 20	o. 111110 01		Yes 2	_		, ,			
ivisior lor Attend after death Director: d in by the	cati	2 Accident	Investigation	28e. Place of Injur	ry - At home	farm, stre	et, factory, off	ice building.	etc. 28	f. Location (S	treet and	Number or I	Rural Ro	oute Number, City
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rafter death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	ertification		Could not be determined	e l	,	,	, , ,	3.		or Town, St	ate)			
lospit hour hour	ပ	4 Homicide 29a. Certifier 1 Certifyi	na Physici:	an: To the best of my k	nowledge.	death occu	rred at the tim	e, date and p	place, and du-	e to the cause	e(s) and m	nanner as st	tated.	
Division of Vital Records, P.O. Box 68760, vithin 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medica	Examiner:	On the basis of examin	nation and/o	r investiga	ation, in my op	inion, death o	occurred at th	e time, date a	nd place,	and due to	the cau	se(s)
wit To	Mec	29b. Signature and title of c		and manner stated.			29c. Li	cense numbe	er		29d. Dat	e signed (A	Aonth, D	ay, Year)
		MI	R.	ull M	A		0	.C.M.E.			Noven	nber 24, :	2008	
		30. Name and address of po	erson who c	completed cause of dea	ath (Item 23	a)								
		Melissa Brassell,		sistant Medical E			Penn Stree	et, Baltimo	re, MD 21	201				
St	ate	31 NOV 2 (M 6th 200)	ear)	32. Registrar's	Sign ture	W								
Regis		MOTA U LOO		The same										

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

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/M	edica
Exa	mine

Funera Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Modical Exeminer must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	Registrar	Cer	rtificate of L	Death	F	eg. No.	000 0000	0					
	1. Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·			2. Date of Dea Month	th Day	3. Time of Death						
ian ical	MEIVIN CUITTENDEN CODDE	TT. JR.	NOV. 17, 2008 14										
ner	An English Name (If not institution sing street and not		4b. City, Town, or	Location of Death		4c. County							
	CHESTER RIVER HOSPITAL O	ENTER	CHESTER	TOWN	KENT	1							
		7. Age (In yrs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day	Vaar)	9. Birthplace (State or Foreign	n					
	048-18-6987 ¹⅓м 2□ F	80 Yrs.	Months Days	Hours Min.	NOV. 30.		CONNECTICUT						
	Usual Residence of Decedent												
١.	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits						
8	MD QUEEN ANNE'S	GRASONVIL	LE				1 X Yes 2 □ No)					
ire	10e. Street and Number		10f. Zip Code			What Country?							
7	210 MOUSLEY ROAD		21638	1		USA							
Funeral Director	11. Marital Status 12. Was Dece Armed Fo	dent Ever in U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-		ce - American Indian,						
		2 No	1 □Yes 2 👿 No	Specify:	riiouri, cio.,		ck, White, etc.						
À	2 3 L Widowed 4 L Divorced Year or Da	ates1946-1947	TES ZENO	Ореспу.		Specif	y: WHITE						
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	ation Jurina most of work	ina	16b. Kind of B	usiness/Industry						
au	Elementary/Secondary (0-12) College (1	-4or 5+)	kind of work done d DO NOT use retired,)	9								
00	5 12 -0	- SUPE	RVISOR			-							
B	17. Father's Name (First, Middle, Last)	ne)											
MELVIN CHITTENDEN CORBETT, SR. DOROTHY SKINNER													
	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
	MELVIN C. CORBETT, III/	SON 506 K	EMEYS COV	E, BRIAR	CLIFF MA	NOR, N	Y 10510						
	20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Location	- City or Town, State						
	1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from 3 ☐ Donation 5 ☐ Other (Specify)	CHESAPEA	KE CREMAT	ION 11-1	9-2008	STEVEN	SVILLE, MD						
	21. Signature of Funeral Service Licensee	CENTER	2. Name and Addres	s of Facility	I C MINI	436 737377	DAT HOVE	_					
	Kick of Selfert	en 1	56 SHAMRO	CK RD. CH	HESTER,	AM FUNE MD	CRAL HOME						
	23a. Part 1. Enter the disease, or complications that c	aused the death. Do not ent					Approximate						
	shock, or heart failure. List only one cause on e Immediate Cause (Final		c . l			•	Onset and Death						
	disease or condition resulting in death)	erobacteror as a consequence of):	7 61000	ae pri	eumer	<u></u>		_					
	Cha	Change obstruction and movement of sever 5 years											
Ģ.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
Examiner	cause. Enter Underlying Cause (Disease or injury						R, NY 10510 Location - City or Town, State EVENSVILLE, MD FUNERAL HOME Approximate Interval Between Onset and Death						
Exa	that initiated events c												
n/Medical								_					
		come of pregnancy	_			23d. Da	ate of delivery						
1.5	in the past 12 months? 1 ☐ Live I 1 ☐ Yes 2 ☐ No 4 ☐ Preg	nant at time of death 5	∃Ectopic pregnancy ∃Other <i>(specify)</i>	/			,						
Physicia	9 Unknown 9 Unkn	own											
d >	Part II. Other significant conditions contributing to de	eath but not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to the cause of death?						
Completed by	Atrice Ebrilletis	<u> </u>			ix	es 2 No	3 Probably 4 Unknown	n					
ete					24a. Was a	n 24h	Were autopsy findings available	0					
8					autop	SV .	prior to completion of cause of death?	3					
ပိ	05 W				1 □Yes	2 2 No	1 ☐ Yes 2 ☐ No						
Be			ot 3 🗆 DOA Othe	26. Place of Deat		-		_					
<u> </u>	1	npatient 2 ER/Outpatier	IL 3 L DOA	4 LI Nursing H	ome 5 Resid			_					
i c	27. Manner of Death 28a. Date (Mon	of Injury 28b. Time of Injury Injury	Work		28d. Describe h	ow injury occur	red						
2	2 Accident investigation 3 Suicide 6 Could not be			res 2□No	005 11 (0			_					
i i	4 ☐ Homicide determined 26e. Place buildi	of Injury - At home, farm, str ng, etc. <i>(Specify)</i>	eet, lactory, onice		City or Tow	treet and Numi n, State)	ber or Rural Route Number,						
Ö	29a. Certifier TR Certifying Physician: To the	hant of mules and a deal of	h cooursed of the - "	no date and da	and done to the	200001-1							
Medical Certification: To	29a. Certifier (Check only one) 2 Medical Examiner: On the band of the band on the band on the band on the band on the band	asis of examination and/or in	rroccurred at the tin vestigation, in my o	ne, uate and place pinion, death occur	, and due to the or rred at the time, o	ause(s) and mate ate and place,	nanner as stated. and due to the cause(s)						
Med	29b. Signature and title of certifier	ner stated.	29c Licenso	number		Od Data size :	ad (Month Day Year)	_					
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 18, 2008												
	7			3 . 1		- W -CM le	10/2008						
	30. Name and address of person who completed cause	e of death (Item 23a) (Type,	Print)	n. un MV	7 7110	0							
				W-1 (-CL	2102		<u>-</u>	_					
ate	NHIV T U 2000 .	e trar's Signature	1										
trar		WHEN IN I	(1034)										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death edent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 510 M 2008 /Medical ovember a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL SAUSBURG NICOMICO TENIASUVA Centa If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 219-34-8034 Usual Residence of Decedent 1 M 2 F Months Days Hours Min. lay J. **Director** State 10d. Inside City Limits 10c. City, Town or Location show Department of Health and Mental Hygiene. Important: if tiem 23a or 28a-f show important: if tiem 27 is marked other than "natural", or tiems 23a or 28a-f show injury or other traumatic event, the the fice it will be notified at Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐No Specify: ģ Iack 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WOLF 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ Informant's Name/Relationship (Type. Print) SISTEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health a Fruitland 21826 20a. Method of Disposition Location - City or Town, State Pages 1 1 □ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Luneral Service Licensee Isabella W. Bennie Smith Funial Hime Part 1. Les like diseas- or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MRSA PNEMMONIA PSEMBOMONAS Physician MA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ WHI FAILURE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed NEUROGENIC CUSP HAGIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 10 LONANS 1 ☐Yes 2 ☐ No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1√No 1,☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours after the Funeral Direct

certificate be executed Box 68760 P.O. Records, of Vital Division Hospital or Attending

Appenden Coffmen Baltimore, Maryland 21215-0036

Medical completely within To the OWP

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Mon

29c. License number 30067916

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day. Year)

NEVEMBER 17, 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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EUTHERNE

32. Poistrar's Signature 2008

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician ROBERT WILSON CRITTENDEN NOVEMBER 15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER CHARLES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 77 Months Days Min. AUG. TEXAS 552-36-2622 Director 14. 1931 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, I'm Madical Examinar must be notified at 10d. Inside City Limits Director 1 □Yes 2XXNo MARYLAND **CHARLES** WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2803 Brewster Road 20601 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 May Yes 2 □ No ROBERT Armed Forces: 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. " Important: If Item 27 is marked other than " any injury or other traumatic event, "In Man Once." Elementary/Secondary (0-12) College (1-4or 5+) Personnel Director U.S. Federal Govt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Price Crittenden Myrtle Willie Gray RITTENDEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn L. Crittenden/ Wife 2803 Brewster Rd. Waldorf, Maryland, 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory Nov. 17, 2008 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home M01164 3035 Old Washington Rd. Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be execut burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but hot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to re cause of death? Be Completed by 3 robably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □ Yes 2 □No After this certification funeral director, p 25. Was case/ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yeş Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 □Yes 2 □No 2 Accident 24 hours after death Funeral Director: 6 ☐ ould not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, eath occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated. (Che within 2 one) 29b. Signatul 29c. License number and title of certifier 29d. Date signed (Month, Day, Year, address of person who completed cause of death (Item 23a) (Type, Print) 30 Name and 20602 31. Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

32. Registrar's Signature

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18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 P Robert Warren Compton November 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Days Hours 1X M 2 □ F 218-52-6737 24. 52 1955 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Frederick Woodsboro Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9700 Gravel Hill Rd. 21798 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🛛 No Specify. Specify. 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) technician automobile 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert E.L. Compton Barbara Casady 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9700 Gravel Hill Rd. Donna J. Compton/wife Woodsboro, MD 21798 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens 11/25/2008 Frederick, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hartzler Funeral Home Woodsboro, MD 21798 404 S. Main St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

Department of Important: If it any Injury or o

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show dieal Examiner must be notified at

Director

Funeral

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Completed

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

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3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

burial-tran the

Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	/8-2019 (1 cg /60		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the un	derlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?	Hamital		th (Check only one)	
1 ☐ Yes 2 ₹ No	Hospital: 1 Inpatient 2 ER/Outpatien	t 3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how injur	ry occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		et, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	Physician: To the best of my knowledge, death caminer: On the basis of examination and/or invand manner stated.			
29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year)

D14626

State Registrar 501

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2010305

31. Date filed (Month, Day, Year)

MO

32. Registrar's Signature

			State of Maryland / Department of Health and I	Mental Hy	/giene		22607
			1 - State Certificate of Death		Reg. No.	2008	38687
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Do Month	eath Day		3. Time of Death
5	/Medio		KELLY 5 CLAPSADOLE	NOV	24	2008	7:13 PM
· A	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CNIVERSITY OF MARYLAND MEDICAL CITTER BAUTIMORE		4c.	County of Deat	h
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bi	irth	Q Rirt	hplace (State or Foreign
	Funeral Director		1 M 2 □ F Months Days Hours Min.	May 1	ay, Year)	Co	rvland
			216-04-2169 41 TIS. Usual Residence of Decedent	ray I	, 150	or Ina	Lytand
	aryland show		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	the Mar 28a-f s	cto	MD Carroll Union Bridge				1⊠Yes 2□No
	ith the	Director	10e. Street and Number 10f. Zip Code		10g. Cit	tizen of What Co	untry?
	th wi		102 S. Bellevue St. 21791			U.S.A.	
	items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerts	pecify Yes or N o Rican, etc.)	0-	 Race - Ame Black, White 	
36	vurs after death with the Maryla "al", or items 23a or 28a-f shor Evaniner must be notified at	by F	1 Never Married 2 Married			Specify:	
응	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Even in a mat be notified at	ed k	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Ki	Wh ind of Business/	ite Industry
5.	in 72 n "na	Completed	(Specify only highest grade completed) (Give kind of work done during most of work	king			,
212	withir giene. r than	m _O	Elementary/Secondary (0-12) College (1-4or 5+) auto body technician		aut	tomobile	2
٦	al Hygid other vent, II	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle	e, Maiden	Surname)	
/ai	should be f and Mental I s marked of sumatic ever	2	Steven K. Clapsaddle Bonnie	e Broad	wateı	r	
Maryland 21215-0036	2 sho and is ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ru	ral Route Numi	ber, City o	or Town, State, 2	(ip Code)
2	ges 1 and 2 should be filed within 72 ho tt of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, I'w Medical		Bonnie Clapsaddle - mother 102 S. Bellevue St.,				
o re	Pages 1 nent of H int: If ite		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		ocation - City or	
altimore,	t. Partmentant:		4 Donetion 5 Other (Specify) All County Cremation 11/2	5/2008	Syl	kesville	, MD
Baj	permit. Pages Department of Important: If it any Injury or once.					eral Hom	
			23e. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac			4D 2179	1 Approximate
_			shock, or heart failure. List only one cause on each line.	orrespiratory	arrest,		Interval Between Onset end Death
,	Physician /Medical		disease or condition a. SEVERE ACIETIC HIND MITRAL ST	EN0212			5 YEARS
	Examiner		Due to (or as a consequence of):				
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events c.				
·M.	cuted nd ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury I that initieted events				
0,0	e exe an ar rrial-tı	Ä	resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dical					
9		Med	IF FEMALE:	0			
Вох	eath certific attending p for use as	jan/	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date of del Month	ivery Day Year
P.O. I	Physician: The law requires that the death certific this certificate has been signed by the attending rail director, page 2 should be detached for use as	Completed by Physician/Me	1 □Yes 2 □No 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown				,
	es that th igned by be detach	P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ds,	w requires that the de been signed by the should be detached	d b	END STAGE RENAL DISEASE, COROLLARY ARTERY DISEASE	1/2	Yes 2	□No 3□Pr	obably 4 🗆 Unknown
Ö	v requ been should	ete		24a. Was	e an	24h Were au	topsy findings evailable
Re	ne law e has ge 2 s	m d	HERATITIS C	auto	opsy formed?	prior to death?	completion of ceuse of
a	n: Th ificate or, pa		25. Was case referred to medical 26. Place of Dea	1 Yes		1 □Yes	2 5 No
S	rslcia s cert lirect	o Be	examiner?			6 ☐ Other (Spe	oife)
o	g Phy er thi	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe			Sily)
<u>io</u>	Attending r death. ector: After by the fune	atio	2 Accident investigation M 1 Yes 2 No				
Division of Vital Records,	r Atte er de recto	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	(Street an	nd Number or Ru	ıral Route Number,
Ö	ital or rs afte ral Dir red in	Cer					
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page.	Medical	29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	e, and due to the rred at the time	e cause(s e, date and	s) and manner as d place, and due	s stated. to the cause(s)
	To the within 2 To the comple	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Da	ite signed (Monti	h, Day, Year)
	F 3 F ö		MO 18976		NOV	24 200	%
	f_i		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1000	-1 460	0
	4		ELISE A MALECKI, MD UMMC, 22 S GREENE ST	BALTI	MORE	, MO	21301
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 0 4 2008				
	Registi	ar	DEO AZ TOOR PROPERTY IN THE PARTY				

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day, Month **Physician** 8:17pm 27,2008 November George Atlanta Caldwell, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Washington County Hospital
Social Security Number 6. Sex 7. Age Hagers Lowing If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday, **Funeral** 1 € M 2 □ F Months Days Director MD 062-22-3838 September 21,1927 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hyglene.
To 15 marked other than "natural", or items 23a or 28a-f show the traumatic event, the Nacion Examiner must be reafficial. Director 1 ☐Yes 2 XNo MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14132 Orchard Ridge Road 21750 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White \$ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Govenment R <u>Supervisor</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Atlanta Caldwell, Sr. Pearl Breakall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tra once. Lana E. Weller/Daughter 14140 Orchard Ridge Road Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem.Park 12/02/2008 | Hagerstown, MD 22. Name and Address of Facility 141 West Main Street Ignature of Juneral Service Licensee Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMONIA /Medical Due to (or as a consequence of): Examiner Cancer LLWA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the buriaf-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has 1 □Yes 2√No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Box 68760, P.O. of Vital Records, Physician: Division To the Hospital or Attending

Baltimore, Maryland 21215-0036

iours after death.

neral Director: After this certific filled in by the funeral director, within 24 hours a

To the Funeral I Medical

State

Registrar

4 Homicide

(Check only one)

DEC 04

29a. Certifier

and manner stated 29b. Signature and title of certifie

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11260 Wascen MD Mammad DAY Court 31. Date filed (Month, Day, 32. Registrar's signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				1 - State Registrar	——————		rtificate of		I	Reg. No.	8 35589		
## Family Family	П	Physicia	an		M 4 0				Month	Day Ye	ar		
Sell a Blue Ball Road Commonwealth Commonwealt						ouse	4h City Town	or Location of Deat					
Social Security Purposed 10	ا رسد	Examin	er						J 1		Catt		
Description of the Control of the		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birt		Birthplace (State or Foreign		
100. Date 100. Charty 10		Director		213-30-7919	^{M 2Ll F} 90	Yrs.	World Days	Tiodis IVIII.	DEC 25,	, 1917 No	rth Carolina		
Lonnie Crouse Amy Clyde Reynolds 19a. Informatis Namo-Prelisions (Type, Print) 15b. Malling Address (Silvert and Number of Paul Rouse Number of Paul		and ow			10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits		
Lonnie Crouse 19a. Internate Namo-Pleatanean (Prop. Prof.) 19b. Mailing Address (Siever and Number of Plata		Maryl f sho	힏		F	11/+ on					1 □Yes 2 🎇 No		
Lonnie Crouse 19a. Internate Namo-Pleatanean (Prop. Prof.) 19b. Mailing Address (Siever and Number of Plata		r 28a	irec		15	IKLOII	10f, Zip Code			10g. Citizen of What	Country?		
Lonnie Crouse 19a. Internate Namo-Pleatanean (Prop. Prof.) 19b. Mailing Address (Siever and Number of Plata		th with	a D	3813 Blue Ball Ro	ad		21923			United States			
Lonnie Crouse 19a. Internate Namo-Pleatanean (Prop. Prof.) 19b. Mailing Address (Siever and Number of Plata		ems :	ner	11. Marital Status		.S. 13.\	Was Decedent of I	Hispanic Origin? (S	Specify Yes or No to Rican, etc.)	- 14. Race - A			
Lonnie Crouse 19a. Internate Namo-Pleatanean (Prop. Prof.) 19b. Mailing Address (Siever and Number of Plata	36	s after	ž.		1 ∐Yes 2∭X No If Yes, Give				,	Specify			
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Evelyn E. Crouse/Wife 3813 Blue Ball Road, Elkton, MD 21921 200. Location - City or Town, State 200. Location - Ci	nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle,	Maiden Surname)			
Evelyn E. Crouse/Wife 3813 Blue Ball Road, Elkton, MD 21921 200. Location - City or Town, State 200. Location - Ci	<u>Y</u>	ould to Men narke	ဥ										
Physician Modical Examiner Physician	<u>a</u>	d 2 sh th and 7 is n traun	14		•	1	•				e, Zip Code)		
Physician Modical Examiner Physician	<u>စ</u> ်	Heal Heal tem 2 other							Date		or Town, State		
Physician Modical Examiner Physician	Ö E	Pages ent of nt: If i			moval from State Ch	cemetery, cren erry Hi	natory or other pla	^{сө)} Nove		Ch II	•11 MD		
Physician Modical Examiner Physician	a =	partm portal y inju			Me		. Name and Addr	ess of Facility	2000	Cnerry H	III. MD		
Physician Medical Examiner Physician Medical Examiner The physician and physician an	m	De a la la la la la la la la la la la la l	i	Donald &	Hicks	10	icks Home 03 W. Sto	e for Fun ockton St	erals, F reet. El	kton. MD	21921		
PRYSICIAN Medical Examiner Part				23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deat cause on each line.	th. Do not ent	er the mode of dy	ng, such as cardia	c or respiratory a	rrest,	Interval Between		
Sequentially list conditions. Sequentially list conditions.	5			disease or condition	MYOCARD	144	INFANC	WOIT.			1 1		
Dee to (Jee as a consequence of): Part				resulting in death)	· ·		•	_					
Due to (or as a consequence of): d. ATMIAL FLYNLLATION WEEKS IF FEMALE: 230. Use december pregnant in the past 12 months? 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Ves 2 No 3 Probably 4 Unknown Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an all subgray performed? 1 Ves 2 No 1 Ves 2			e.	Sequentially list conditions, if any, leading to immediate by the conditions of the									
The content of the	7	uted d ansit	in in	cause. Enter Underlying Cause (Disease or injury			IBROSL	s			YEARS		
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Second S	ပ္ပ	law re as be 2 sho	plet								autopsy findings available		
26. Place of Death (Check only one) 27. Manner of Death Place of Death		ate Jag	Som						perfo	rmed? death	1?		
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Signature and ditte of certifier (Check only one) 29b. Signature and ditte of certifier (Check only one) 29c. License number (Check only one) 29c. License number (Check only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVIVI GAN-EL 30 4-306 North Street Sufficed Suffi	uo	ing Afte une	tion	1 Natural 5 Pending	(Month, Day, Year)		Wo	′k?	28d. Describe r	now injury occurred			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Signature and title of certifier (Check only one) 29b. Signature and dide to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier (Check only one) 29c. License number (29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	isi.	Atten r deat ctor: by the	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	l ome, farm, stre		1100 2 110	28f. Location (S	Street and Number or	Rural Route Number,		
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Signature and title of certifier 29b. Signature and didense of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) Novcusses all due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Novcusses all due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Novcusses all due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Novcusses all due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Novcusses all due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Novcusses all due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Novcusses all due to the cause(s) and manner as stated.		al or safte	Sert	4 Homicide	building, etc. (Special	fy)			City or Tov	vn, State)			
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 31, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVIN GAN-EL 304-306 North Street Sult 33 ELECTUM MAY LIMB 21931		ospit hour unera ely fille		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine	cian: To the best of my known.	owledge, deatl	n occurred at the t	ime, date and plac	e, and due to the	cause(s) and manne	r as stated.		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVIN GAN-EL 304-306 North Street Sult #3 ELECTUM MAY LIMB 21921		the H hin 24 the F mplets	/ledi	one)	and manner stated.								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID GAN-EL 30 4-306 North Street Sult #3 ELKTUW MAY LIND 21921		vit Co.	_										
DAVIN GAN-EL 304-306 North Street Sult #3 ELATUW MAN LIND 21921					polated agrees of death (1)-	m 22e\ /T:		, , , , , ,			, , , , ,		
State 31. Date filed (Month, Day, Year 2008 22. Registrar's Stonature		u		DAVIN GAN-EL 3	04-306 No	++h > 5-	breet Su	Ht #3	ELATUR	J MAN LA	wo algai		
				31. Date filed (Month Bey Near 100)	Emo Bonietrar's Sing	turo Pensas	Ma 2			•			

08-08901 Jessica Daffin

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State of Maryland / Department of Health and Mental Hygiene

			For State	,	Certific	ate of	Death				9. N o.	
F	hysicia		Decedent's Name (First, Midd	le,Last)						Date of Death Month		3. Time of Death 2307 hrs
eri:cal	Examir		JESSICA LA	NDON DAFFIN						Month November		
		4	a. Facility Name (if not institution			41	c. City, Town, or	Location of	Death		4c. County of Talbot	Death
			Easton Memorial Hos				Easton	Total III	- L	Data of Dat		Birthplace (State or Foreign :
F	uneral		5. Social Security Number	6. Sex 7. A9	e (In yrs. last bir	rthday)	If Under 1 Year	_	Min			Country)
Di	irector	- 1	215-92-9500	1 M 2X F	43	Yrs.	Wionians Days	110010		MAY 12	,1965	MD
			Usual Residence of Decedent									10d. Inside City Limits
	any		10a. State 10b. County		10c. City, Town							1 Yes 2 X No
	show nce.	5	MD T	ALBOT	E	ASTON				1.0	0:::	
	28a-f	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Who	i
040	ms 23a or 28a-f show any be notified at once.		30149 MATTHEW	STOWN RD				21601				SA
2 1	ns 23 be no	Funeral	11. Marital Status	12. Was Deceden Armed Forces		13. Was	Decedent of Hises, specify Cubar	spanic Origin, Mexican,	in? (Spec Puerto Ri	ify Yes or No- can, etc.)	14. Race White	- American Indian, Black, , etc.
Acath	or ite	Ĕ		1 Yes 2	X No		Yes 2 X No				Specify:	WHITE
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စ္ဆ	nan " lical]	Completed	Elementary/Secondary (0-12	College (144 of	31,	TJAT	TRESS				REST	AURANT
5-0036	Hygiene. other than the Medical	E .	12 17. Father's Name (First, Middle			WEXT	IRABB	18.Mother	s Name (F	irst, Middle, I	Maiden Surname)	
215- 215-	ed Hy	ø		DAFFIN, SR.				S	HIRL	Y ALLI	<u>s</u> n	
212	should be filed within 7, and Mental Hygiene. 77 is marked other than natic event, the Medical	10 B	19a. Informant's Name/Relation		1	19b. Mailing	Address (Stre	et and Num	ber or Ru	ral Route Nur	nber, City or Tow	n, State, Zip Code)
MD	and 2 should be in lealth and Mental tem 27 is marked traumatic event,	-	SHERYL D. LET	TAU/SISTER		347	WYE RD	., QU	EENS?	rown, 1	D 21658	
6, MD 21215-0036	ss I and 2 s of Health as If item 27 her traums		20a. Method of Disposition			e of Dispos natory or oth	ition (Name of ce	emetery,		Date	20c. Location -	City or Town, State
or o	iges l it of l t: If other		1 XBurial 2 Cremation		late		LL CEMET	ERY	12/0	6/2008	EASTON	, MARYLAND
Baltimore,	it. Pa irtmei ortan iy or		4 Donation 5 Other 21. Signature of Funeral Service	Specify: ce Licensee	DIREL	100.1	In an a small Address	o of Encility	,			
Ва	permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum			MERCEA	Cos	26	AH D OF	RRTSO	N ST	RAS'	ron. MD	ERAL HOME PA 21601
	ysician		23a. Part I. Enter the disease,	or complications that cause	ed the death. Do	not enter t	he mode of dying	, such as c	ardiac or i	respiratory an	est, shock, or he	Approximate interval Between Onset and
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760,	phys the bu	-	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, outon the 1 Live birth	come of pregnan		etal death 3	Ectopi	c pregnan	icv	23d. Date o Month	Day Year
89	ath certifi attending or use as	sician	past 12 months?		at time of death		ther (Specify)		, ,	•		
Box 687	e death the atte ed for u	ysic	1 Yes 2 No 9 ✔ L	0								41.00
Ö	that the d ned by the detached	/ Phy	Part II. Other significant con	ditions contributing to de	ath but not resu	Iting in the	underlying cause	e given in P	art I.			ribute to the cause of death? Probably 4 Unknown
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<u>i</u>	ysiciar his cer directo	a a	examiner?	A Long Marks and a second	atient 2 🗸 EF	R/Outpatier	nt 3 DOA	Other ₄	Nursing	Home 5	Residence 6	Other:
Division of Vital Records,	ling Phy After th funeral of	-	1 ✓ Yes 2 No 27, Manner of Death	28a. Date of I		8b. Time of	, , I	ijury at Wor			how injury occu	rred
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<u>isi</u> .	tal or Attens rs after death ral Director:	ļ g		rivestigation 28e. Place of	f Injury - At hom	e, farm, str	eet, factory, office	e building, e	etc.	28f. Location	(Street and Num State) 3014	ber or Rural Route Number, City Matthewstown
Ξ̈́	ital o irs afi ral D	Certification:	4 Homicide	letermined (Specify)			house ————			Easto	n, MD	
	Hospit 24 hour Funer		29a. Certifier 1 Certifying	g Physician: To the best of	f my knowledge,	, death occ	urred at the time,	date and p	lace, and	due to the ca	use(s) and mann	er as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical E	g Physician: To the best of e Examiner: On the basis of e and manner state	examination and ed.	or investig				t trie time, dat		
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			met 2	half-real-real-real-real-real-real-real-real			0.0	C.M.E.			Novembe	er 27, 2008
			30. Name and address of per	son who completed cause	of death (Item 23	3a)	Otropi Dell'	more Lar	31201			
				Assistant Medical Ex			Street, Baltir	nore, MI	212U1 ا			
		34-4	31. Date filed (Month, Day, Ye	4 2008 32 Feets	strar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marjorie Lou DeLair 5:35 P M November 11 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 492-24-1729 1 ☐ M 2 🙀 F 84 Director August 19, 1924 Iowa Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Evaruing must be redified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Yes 2 □ No Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9419 Glade Avenue 21793 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ white Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Caregiver Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Fred McKnight Helen Hamm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David DeLair - Son 9419 Glade Avenue, Walkersville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Stauffer Crematory 11-17-2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Juneral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Muse (Final **Physician** MONIC disease or condition resulting in death) MEARS /Medical Due to (or as a consequence of): **Examiner** 4EARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ GASTROINTES TINAL 1 Pres 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes _2 ☐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

State Registrar

Roland Miller, M.D. 31. Date filed (Month, Day, Year)

NOV 1 8 2008

29b. Signature and title of certific

4 Culwell Drive, Mt. Airy, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

126499

29d. Date signed (Month, Day, Year)

11-12-08

State Registrar 31. Date filed (Month, Day

Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-08921 State of Maryland / Department of Health and Mental Hygiene Lisa Ennals Certificate of Death 1- For State 3. Time of Death 2. Date of Death Registrar Month November 27, 2008 . Decedent's Name (First, Middle,Last) 2021 hrs Physician/ Examiner isa 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Dorchester Cambridge Dorchester General Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (in yrs. last birthday) 5. Social Security Number **Funeral** Months Days Country avy land Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 1 V Yes 2 No items 23a or 28a-f show ust be notified at once. 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number U5 1.20 6 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11. Marital Status or items 2 Armed Forces? Never Married 2 V Married Yes Specify: Yes 2 V No specify: If Yes, Give Year Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed by 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Ker 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nartha Be 01 (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 2' permit; Pages 1 and 2 should Department of Health and M. Important: If item 27 is minjury or other transmatic e lel 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Removal from State 08 1 V Burial Cremation 3 6 2 aubridg Bethe Cemeter Other Specify Donation 5 22. Name and Address of Facility
HENRY FUNERAL HOME
510 Washington Sti P. A 21. Signature of Funeral Service Licensee Home, de of dying, such as cardiac or respiratory arrest, shock, or heart hysician 1edical .kaminei

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

	23ac Part I. Enter the disease, or complications that caused the death. Both of the transfer failure. List only one cause on each line.	disease			Death
	Immediate Cause (Final disease or condition resulting in death) a. <u>Hypertensive cardiovascula</u> Due to (or as a consequence of):	dibease.			
er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	Par pull I			
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
	d. X UNPENDED AMENDED 23a,27,per ME g887	1/20/09 TT			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specify,	3 Ectopic pregnancy		Date of delivery Month Da	ay Year
Physic	1 Yes 2 No 9 ✓ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.	23e. Did tobacco		ne cause of death?
ompleted by			24a. Was an autopsy performed?	24b. Were aut prior to condeath?	opsy findings availab ompletion of cause of
- U	25. Was case referred to medical 26	Place of Death (Check on			
o Be	examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DO		Home 5 Reside	nce 6 Other	
F -	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28	1 Yes 2 No			
ertification	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, C 3 Suicide 6 Could not be determined (Specify)		28f. Location (Street a or Town, State)		
- C	2ga, Certifier . Decriping To the best of my knowledge, death occurred at the ti	ime, date and place, and o ppinion, death occurred at	due to the cause(s) at the time, date and pl	nd manner as stat ace, and due to th	ed. le cause(s)
Modical	and manner stated. 29b. Signature and title of certifier 29c.	License number	290.	Date signed (Mo	Hui, Day, real)
2	Mousone Melforde	O.C.M.E.	No	vember 28, 2	008
	the state of person who completed cause of death (Item 23a)	eet, Baltimore, MD 2	21201		

ORIGINAL

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^Day8, 2008 **Physician** November 10:00 A M Virginia Ward Elkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Sandy Spring Friends Nursing Home If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth Nov 12, 1918 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗗 F 90 067-32-4298 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: if tiem 27 is marked other tran "neturel", or items 23a or 28e-f show any injury or other treumetic event, the Madical Examinar many once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ₹ No Director MD Sandy Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20860 USA 17330 Quaker Lane #E-3 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gertrude Hamilton Joseph Wile Ward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 17330 Quaker Lane #E-3 Sandy Spring, MD 20860 William S. Elkins/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 11/19/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly I. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failtie. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ALLINE /Medical Due to (or as a consequence of) Examiner QS SEHILE SEMENTIF Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to |or as a cons- uence of Examiner The law requires that the death certificate be executed YPERTENSION and Due to (o) as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Month Day Year jo 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Linknown á 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has 1 ☐ Yes or Attending Physicien: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No this 28d. Describe how injury occurred 28c. Injury at Work? after death. 27. Manner of Death 28b. Time of 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel I To the Hospitel 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50 30. Name and ordress of person who complete cause of death (Item 23a) (Type, Print) BRIGGS CHARLY Rd SILVER SPRING, MI 20905 John E 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 9 2008

DHMH 17 Rev 1/2001

Registrar

Breeke

10:25 Am

800E

November 13,

M. Elloit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 14:39 TATRICK Bower Nev 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltinure Baltimore Meryland Medical Cente University '. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 15 9. Birthplace (State or Foreign Funeral Hours 1 DMM 2 □ F Months Days Min. 1964 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminer must be notified at once. 1 ☐ Yes 2 No Directo Maryland Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20639 United States 1610 Solomons Island Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Completed by 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) auto body. Ins. adjuster automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Leroy Elliott Barbara Bowen 2 19a. Informant's Name/Relationship (Type. Print)
Barbara Bowen Elliott— mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 256 Prince Frederick MD 20678 20b. Place of Disposition (Name of cemetery, crematory of other place) Nov 26 2008 Huntingtown UM Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HUntingtown Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple myclom /Medical Due to (or as a consequence of): Examiner MRSA preumoni Sequentially list conditions, Due to for as a nonsequence off-If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Sepsis and attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of ath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 □ Yes 2 🗌 No hours after death within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifie 2008 1720281783 NOV. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIKram Green 11001 Gill 5.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32 egistrar's Signature

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 1 7 ay / 0 8 ar **Physician** 4:35 pm Maimina Fall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 03/03/63 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. 1 □ M 2 □ KF 45 none Senegal Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mertial Hygiene, tiem 523 or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other than "matural", or items be notified at other traumatic event, it is finished in the minish be notified at Director 1 ☐ Yes 2 No Hyattsville MD Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20782 Senegal 5006 36th Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2√□No Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hair Stylist Cosmetology 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aida Mbaye Ousmane Fall ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dethioro Mbaye / Husband 4721 Section Ave. Cincinatti, OH 45212 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ment of H ant: If ite ury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. Family Cemetery 11/24/08 Dakar, Senegal 22. Name and Address of Facility Universal Mortuary Inc. 21. Signature of Funeral Service Licensee 411 Kennedy St. NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a Ö 1 ☐ Yes 🛠 😾 No 9 ☐ Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si ; page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☑ No 2**7** No Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur P55120 death (Item 23a) (Type, Print) Hospital Drive Cheverly Mp20785 3001 31. Date filed (Month, Day, Year) State 1 2003 NOV 2 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:00 A M NOVEMBER 15 2008 LESTER WILLIAM FISCHER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S 121 PARKS ROAD CHESTER 8. Date of Birth (Month, Day, Year)

MARCH 19, 1929 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign
Country) Social Security Number **Funeral** Days Hours Months 1**X** M 2□ F 214-24-9959 79 MARYLAND Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at gnoe. 1 ☐ Yes 2X No Director MARYLAND QUEEN ANNE'S CHESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21619 121 PARKS ROAD UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. 1 ▼ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No ģ Specify: WHITE 3 X Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC AUTOMOTIVE 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FREDERICK EARNST FISCHER ELSA GUMBRICK ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an ant; if item 27 is r BRENDA LEE FISCHER/DAUGHTER 113 THOMPSON AVENUE, QUEENSTOWN, MARYLAND 21658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State NOVEMBER 19 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (*Specify*) 3 ☐Removal from State STEVENSVILLE CEMETERY: 2008 STEVENSVILLE, MARYLAND 21. Signature of Fundal Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. (AB 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ASpurnan /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): LEFLY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trar Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate l 1∐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician: Hospital or Attending hours after deatl uneral Director: 24 hours a' e Funeral I

Saltimore, Maryland 21215-0036

within 24 10

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

4 Homicide

29b. Signature and title of certifier

JEFFREY L. Ullery

29a. Certifier

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completely

32. Registrar's Signature MOV

2540

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended #5perFH FCHD. KS 11/2 (Persificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2008 Forbes Thomas WILLIAM // /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PATRICK FREDERICK FREDERICK WEST 1505 If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. 8. Date of Birth (Month, Day, NOV 12, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months NEW JERSEY Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at FREDERICK PRENERICK 1 Yes 2 No Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code WEST PATRICK ST 21703 USA 1505 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
1 Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1☐ Yes 2☐ No 3altimore, Maryland 21215-0036 Specify: Specify: WHITE 2 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other trainment. EXTERMINATING COMP. Elementary/Secondary (0-12) College (1-4or 5+) PEST CONTROL 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JACKSON WILLIAM T. FORBES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47401 (SON) LINCOLN ST BLOOMINGTON INDIANA 3515. IAN FORBUS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SMITHS BURG CRUM. NOV. 18,2008 SMITHSBUR 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FUN, 12ME 21. Signature of Funeral Service License 0 WITST SOUTH ST FREDERICK MP 21701 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest allure. List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart ailure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ANTE MOSCEROTIC

Due to (or as a consequence of): CARDIOVASCULAR 0 4m /Medical DICEASE Examiner Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of death certificate be executed burial-transit Exami and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☑No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, THROMB VENOUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 e Hospital or Attending | 24 hours after death. e Funeral Director: After 5 Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined within 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many stated. To the 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEKAR NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KNEDERICH

State Registrar JULIO

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Date filed (Month, Day, Year)

MOBAUGHMAY'S Lone Suikiyo

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		For State Registrar		State	e of M	aryland / [•	rtment <i>tificate</i>			and M	1ental Hy	/gien Reg. N	7111	8	38700
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Examin	er	4a. Facility Name (I	0	n, give street an	ld number) Nad in	al Can		4b. City, To	own, or	Location of	of Death		4	c. County of	Death.	co
Funeral Director		5. Social Security N 157-20-2	lumber	6. Sex 2 1 2 M 2	7. Ag	e (In yrs. last bir 78	rthday) Yrs.	If Under 1 Months	Year Days	If Under: Hours	Min	8. Date of Bi (Month, D MAY 30	av. Year	30	Coun	lace (State or Foreign try) JERSEY
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permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Exarcitation to other traumatic events.	þ	1 ☐ Never Marr 3 ☐ Widowed		ried 1 [X] If Yes I Year	Yes 2 ☐ s, Give or Dates:	1952-85	1	I□Yes 2	Mo	Specify:				Specify:	WI	HITE
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Eleanor C. Frye 11-26-2008 3:20 A[™] /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 123 East 8th Street, Apt 119 Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-19-1925 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 🗓 F 83 MD 579-30-1467 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M-dical Examiner must be notified at 1 Yes 2 No Director MD Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 123 East 8th Street, Apt 119 21701 **USA** and 2 should be filed within 72 hours affer death v aalth and Mental Hygiene. n 27 Is marked other than "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify. Specify: þ White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Virts Georgianna (unknown) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 Is any injury or other trau Jeanette Snyder Daughter 10500 Rockville Pike, #325, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Resthaven Mem. Grdns 11-28-2008 | Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A.F.H. 21. Signature of Funeral Service Licensee M01222 106 East Church Street Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a const uence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-tran the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 BUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No autopsy performe Be (25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending Physician; The law requires that the death certificate be executed P.O. Box 68760, ed by the a Division or Vital Records, cate has t page 2 sl After t 24 hours after death. filled in by within 24 hor To the Fune completely fi

3altimore, Maryland 21215-0036

Pages 1

Certification: To Medical

30. Name and address of person who completed cause of

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 🖷 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, State

29a. Certifier

32. Registrar's Signature

ath (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2008 Goins 5:35 P M Regina Margaret November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 8, 1935 9. Birthplace (State or Foreign Country) New York 6. Sex **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 220-32-6046 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 7 is marked other than "natural"; or items 23a or 28a-f show traumatic event, the Modest Examinar must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □ No Director MD Prince George's Edmonston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20781 4710 Hamilton Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White \$ 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Regina Margaret Cassidy Frederick Albert Kohnken ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar tem 27 is 13813 Wisteria Drive Germantown, MD 20874 Claudia Regina Schreiber/daughter item 27 r other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 = 6 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Chesapeake Crematory 11/19/08 |Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaty of Funeral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Pancreatic Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 ZWo certificate 1 ☐ Yes 2 No Be funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) hospice 1 ∐Yes 2 💯 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kouatchou, mi 20063748 Jecekyne November 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ARLENE GENIESSE 30 AM 3008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dicomica MOSDICE 8. Date of Birth (Month, Day, Year) 11-17-1964 9. Birthplace (State or Foreign Country) Milford, DE If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 💥 □ F Months 222-56-3471 44 DE Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaminar must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 □ No Director Laurel Sussex Delaware 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19956 US 112 Brooklyn Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2∆ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married レードー ラー ショー Maryland 21215-0036 white 1 □Yes 💥 No Specify: 2 3 ☐ Widowed 4 🕅 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Drapery Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sandra Fleetwood Robert Clendaniel ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2755 Curlew Rd, #78, Palm Harbor, FL 34684 <u> Sandra Figgs - mother</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/18/08 Capitol Crematory: Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Cranston Funeral Home 21. Signature Finer I Service Vicep A. Cranston John 1 P O Box 967, Seaford, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** oggi loggth Sequentially list conditions. Examiner as I consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and as the burial-tra Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? 1 □ Yes _2 2 4 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1501 (1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) relle nnin (Month, Day, Year) NOV 1 State 2008 1

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** November 23 2008 Jack Anthony Gullo, Sr. 4:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Carroll Westminster 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 ₩ 2 □ F Yrs. Director 110-16-3349 84 Oct.15, 1924 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director New Windsor 10f. Zip Code Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number 1000 Wakefield Valley Rd. Funeral 21776 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces: 1⊠Yes 2 □ No If Yes, Give Year or Dates: 1945-46 Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: White <u>გ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 systems analyst Federal government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If Item 27 is marked of any Injury or other traumatic eve once. ပ Charles Gullo Natalie Mesina 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana L. Gullo/ wife 1000 Wakefield Valley Rd. New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) County Cremation 11/25/2008 Sykesville, MD 21. Sign fur of Funeral Service Licen Hartzler Funeral Home New Windsor, MD 21776 310 Church St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ADENOCARCINOMA Immediate Cause (Final OF MONTHS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to in modate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed after death.

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

other

altimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Division

if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

attending physician and for use as the burial-tran the signed by the Completed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Certification; To

autopsy

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 1 ☐ Yes 2 No 26. Place of Death (Check onl one)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation

6 ☐ Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of Injury (Month, Day, Year) 28h Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 Suicide

4 Homicide

154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number A31761 29d. Date signed (Month, Day, Year)

10

Medical

To the Hospital or within 24 hours aft To the Funeral Di

BRIANM, O'CONNER Registrar

04

SOI W. SEVENTH ST. . Registrar's Signature

08-08725 William Harold Green

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Certificate C	of Death	Reg. N	
	Physicia	an/	Decedent's Name (First, Middle, Last)	7.21.27	Date of Death Month Da November 21	3. Time of Death
rea	ical Exami		William Harold Green 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	November 2	4c. County of Death
•			16923 Alcott Drive	Hagerstown		Washington
	Funeral Director		412-24-2105 W - 12	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (N	MWDD/YYYY 9. Birthplace (State or Foreign Country) Tenn.
	aux.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
	×	5	Md. Washington Hag		1 X Yes 2 No	
	72 hours after death with the Maryland n"matural", or items 23a or 28a-f sho ral Examiner must be notified at once.	Director	10e. Street and Number 16923 Alcott Rd.	10f. Zip Code 2.1740	10g.	Citizen of What Country? U.S.A
	with th ins 23a be notif		The state of the s	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
	er death , or iten	Funeral	Never Married 22 Married 1 X Yes 2 No	Yes 2. No specify:	= =	Specify: White
	2 hours aftu "natural" Examine	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Deced	ent's Usual Occupation (Give kind of v most of working life. DO NOT use retii	vork done 16	6b Kind of Business/Industry
	36 in 72 hour han "nati lical Exar	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	ant Engineer	eo)	Schools
	21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	Com	12 17. Father's Name (First, Middle, Last)		(First, Middle, Mai	
	21215 uld be file Mental H marked c	Be	Ralph J. Green	-	D. Shrac	
	MD 2 d 2 should kh and M n 27 is ma	To		ing Address (Street and Number or F 3 Alcott Rd. Hage,		
	Makh akh		20a. Method of Disposition 20b. Place of Disp	osition (Name of cemetery,	Date 2	Oc. Location - City or Town, State
	Baltimore, permit. Pages I an Department of He, Important: If ite injury or other tr		Burial 2 A Cremation 3 Removal from State Smithsbu.	rg Crematory 20		Smithsburg,Md.
	Baltim permit. Pag Department Important: injury or of		121. Ighatarean and a contract	Name and Address of Facility L. Davis Funeral		525 Bradbury Ave. thsburg,Md. 21783
	Physician		28a Aax I. Extending the disease, or complications that caused the death. Do not enter			
W.	/Medical	9	Immediate Cause (Final disease a. Contact Gunshot Wound of Hear	d		Death
			or condition resulting in death) Due to (or as a consequence of): b.			
		iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
/	ed sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
V	760, cate be executed physician and he burial - transit	Medical	d. UNPENDED AMENDED			
	760, cate be physic the buri		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery Month Day Year
	Box 687 death certific the attending	Physician	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregnation Other (Specify)	aricy	Month Day Year
	Boy he death the att	hys	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I	23e. Did toba	acco use contribute to the cause of death?
	ires that the designed by the signed by the detached	<u>چ</u>		is underlying ease given in Facts		2 No 3 Probably 4 V Unknown
	ords, w require ts been si should b	Completed			24a. Was an autopsy	
	eco he law ate has age 2 s	ошо			perform 1 Y Yes 2	
	tal Recian: The certificate ector, page	Be C	25. Was case referred to medical	26.Place of Death (Check		esidence 6 🗸 Other: Scene
	of Vil ing Physic After this uneral dir	101	1 Ves 2 No Inpatient 2 ER/Outpati	on o son	28d. Describe ho	w injury occurred
	on on cuding sath or: Aft	tion	1 Natural 5 Pending Nov 21, 2008 0000 hrs	1 Yes 2 ✔ No	Subject shot	
	Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death To the Funeral Directory. After this certificate has been signed by the attending. Completely filled in by the funeral director, page 2 should be detached for use as it	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Single Family	street, factory, office building, etc.	or Town, Sta	eet and Number or Rural Route Number, City te) ive, Hagerstown, MD
	To the Hospital within 24 hours. To the Funeral completely filled	Se		ccurred at the time, date and place, an	d due to the cause	(s) and manner as stated.
	Fo the livithin 2 Fo the livithin 2 Fo the livithe liv	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	tigation, in my opinion, death occurred	at the time, date ar	nd place, and due to the cause(s)
4		ž	29b. Signature and title of certifier	29c. License number O.C.M.E.	ME	29d. Date signed (Month, Day, Year) November 22, 2008
			30. Name and address of person who completed clube of death (Item 23a))		
	10	L	Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltimo	re, MD 21201	
	Regi:	state strar		and in		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 22, 2008 7:29 November a^{M} Rita Frances Gatto /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Havre de Grace 503 Robin Hood Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 9/5/1924 Days 1 □ M 2√2√F Maryland 217-12-8799 84 Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 🍇 No Director MD Harford Havre de Grace 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21078 503 Robin Hood Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) In home Homemaker 10 17. Father's Name (First, Middle, Last)
Ervin Jenkins 18. Mother's Name (First, Middle, Maiden Surname)
Mary Hudak Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Gatto (Husband) 503 Robin Hood Rd. Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/25/08 4 □ Donation 5 □ Other (Specify) Aberdeen, Maryland Harford Mem. Gdns. 22. Name and Address of Facility Tarring—Cargo Funeral Home, P.A. 21. Signature of Foner Aberdeen, Maryland 21001-3399 23a. Part1. Enter the dis-ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the s 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 2 To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Mann of Death filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Turifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed caus

Day, Year)

2008

31. Date filed (Month)

DEC 03



and

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 **Physician** LE ROY 08057M HARROD NOV 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Regional Hospita Laure If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 050-32-9095 70 **Director** 30, 1938 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Evaminar must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1KIYes 2 □ No Funeral Director Maryland Prince George's Laure] 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8813 Hunting Lane 20708 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No 14. Race - American Indian. Black, White, etc 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify 1 ☐ Yes 2 ☒ No Specify: þ 3 Nidowed 4 Divorced **Black** Be Completed | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Harrod Minnie Williams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Jean Ames (Friend) 1212 42nd Place, NE, Washington DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/8/2008 Hanover, Maryland 21. Signatura of Funeral Service License 22. Name and Address of Facility Latimore Funeral Services, P.A. Harrica 9013 Annapolis Road, Lanham MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coroner **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ao 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation within 24 hours area.

To the Funeral Director: Aft 1 □Yes 2 □No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 28998 SAINI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician 7:55AM Milford Willard Hall 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Adventist Losnital Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Days Hours Min 1⊠M 2□F 85 20, 1923 Aug. Snowden, **Director** 226-34-4112 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event is at most be notified at 1 ▼ Yes 2 No Director Mount Rainier Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20712 4506 24th Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1943–1946 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🖾 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Entertainment Musician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental Pauline Barnes Jarvis Smith Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4506 24th Avenue, Mount Rainier, MD 20712 Terry Hall / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 11/24/2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia Aspiration /Medical Due to (r as e consequence of): Examiner Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit evere Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After this Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Division of Vital Records, P.O. Box 68760 To the Hospital o within 24 hours aft To the Funeral Di

filed within 72 hours after

Maryland 21215-0036

Baltimore,

State Registrar

Camell 31. Date filed (Month, Day, Year) NOV 2 1 2008

29b. Signature and title of certifier

32. Registrar's Signature renue

MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

65183

29d. Date signed (Month, Day, Year)

11/18/08

Physician /Medical Examiner

1 - For State Registrar

10a. State

Md.

Physician

/Medical

Examiner

Funeral

Director

r then "natural", or items 23s or 28s-f ehow the Modical Examinar must be notified at

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permit. Pages 'Department of the Important: if Ite ony Injury or ot one ony Injury or ot one one of the other

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Baltimore, Maryland 21215-0036

Examiner or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Be Completed by Physician/Medical as use ō been signed by the should be detached page 2 s has certificate funeral director ۵ this Certification: To the Hospitel or Attendin within 24 hours efter death.

To the Funerel Director: All completely filled in by the fur

Division of Vital Records, P.O. Box 68760,

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a equence of): c. Due to (or as a consequence of): d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1	very Day Year
Part II. Other significant conditions	performed? death?	
25. Was case referred to medical	26. Place of Death (Check only one)	
examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Vursing Home 5 Residence 6 Other (Spec	ify)
27. Manner of Death 1 Natural 5 Pending investigat	28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? On Month, Day Year) 28b. Time of Work? 1 Yes 2 No	

3 Suicide

29a. Certifier

4 | Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number. City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature of certifier

29c. License number 1002JS74 29d. Date signed (Month, Day, Year)

20850

11/19/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHMED HESHMAT, M.D.

10110 MOLECULAR DRIVE, ROCKVILLE, MARYLAND

31. Date filed (Month, Day, Year) 0 2008

32. Registrar's Signature Spelle ORIGINAL

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Edward 19, 2008 Hagberg 11:20 November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 27320 Clarksburg Road Montgomery Damascus If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Hours Min 11XM 2□ F Days Director Sept 18, 1932 New York 214-28-4622 76 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 15 marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified as 1 ☐ Yes 2 XNo Director Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20872 USA 27320 Clarksburg Road Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 M Yes 2 □ No
If Yes, Give
Year or Dates: 1953–55 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: \$ 3 Widowed 4 Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technician Air Cond. & Refrigeration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phyllis Beatrice Young John Helge Hagberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) wife 27320 Clarksburg Road, Damascus, Maryland 20872 Beverly Ann Howell Hagberg, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 11/20/2008 Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Funeral Service License 26401 Ridge Road, Damascus, Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final ear **Physician** disease or condition resulting in death) /Medical Examiner 6 bro vascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached for 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Be Certification: To

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: To the within 2.

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	as case refer	red to medical		26. Place of Death (Check only one)									
	ŢYes 2[X	No	Hospital: 1 ☐ Inpatient 2	spital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 【 Residence 6 ☐ Other (Specify)									
27. Manner of Dea 1 X Natural 2 Accident		5 ☐ Pending investigation		28b. Time of Injury	M 2	8c. Injury at Work? 1 ☐ Yes 2 ☐ No		ribe how inju	ury occurred				
	☐ Suicide ☐ Homicide	investigation	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Ru								iber,		
(Certifier (Check only one)		ysician: To the best of my liner: On the basis of exam								3)		

29b. Signature and title of certifier Cares 29c. License number 021726 29d. Date signed (Month, Day, Year)

November 19, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles W. Karesh, MD, 26033 Ridge Road, Damascus, Maryland 20872 31. Date filed (Month,

State Registrar

amend line 13 per fd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 10/24/08 dlwState of Maryland / Department of Health and Mental Hygiene 38711														711			
1 - State Registrar Certificate of Death Reg. No.																	
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	Physici Medic		Louis R. Hernandez										er 16, 2008 2240				
	Examin		4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death					4c. County of Death				
	1. 1. 1		Prince Georges Hospital				3						Prince George's				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda					Months Days Hours Min (Month Day, Y					9. Birthplace (State or Fore Country) Puerto Rico				
	Director	al Director	058-16-5286 84 11s. Usual Residence of Decedent					March 29,						1924 Idelto Rico			
	h the Maryland or 28a-f show or outified at		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits												City Limits		
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?				Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - An Black, WI	nerican Indian, lite, etc.			
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ğ			17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maid					den Surname)				
<u>a</u>			Rafeal Hernandez					Felicia Diaz									
ary			19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Str.									or Town, State	Zip Code)				
			William Hernandez/ Son PO Box 6835 Santa Fe, Mexico 87502														
ore			20a. Method of Disposition	emoval from State	20b. Pl	ace of Dispo	sition (Name	e of nerplac	ce)	Da	te	20c. L	ocation - City	or Town, State			
Ē			1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington National Cemetery 11/19/2008 Arlington, VA														
Baltimore,			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home										me				
			Islandrus 16000 Annapolis Road Bowie, MD 20715														
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	ie deg the al	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Other (specify)					. Month Day Teal								
P.0	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		Part II. Other significant conditions contributing to death but not resulting in the underlying cause								23e, Did	Did tobacco use contribute to the cause of death?					
ds,		d by	Diabetes Mellitus Hypoxic Encephalotomy									☐ Yes 2☐ No ¾ Probably 4☐ Unknown					
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E	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2																
<u>`</u>	ysicie s cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	nt 3 DOA	Othor				Residence 6 □Other (Specify)								
0	g Phr ter thi		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury				28c. Injury at Work?					ry occurred	, ,			
<u>i</u>	ath. or: Af	atio	1 X Natural 5 Pending investigation	M 1 Yes 2 No													
Division or Vital Records,	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	ry - At ho . <i>(Sp</i> ec <i>ify</i>	ome, farm, street, factory, office 28f. Locatic City or						n (Street and Number or Rural Route Number, Town, State)						
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	XXX		D16273 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)														
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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 South Greene St., Baltimore, MD 21201 32. Registrar's Signature

P14550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Z000 1:05A M Harrington /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Salisbury If Under 1 Year | If Under 24 Hrs. Wicomico 140Spice 9+ the LaVe 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2 □ F Months Min. Director 215-20-1673 81 12-29-1926 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evandra to use to rediffed at any Injury or other traumatic event, the Medical Evandra to use to rediffed at any Injury or other traumatic event, the Medical Evandra to use to rediffed at any Injury or other traumatic event, the Medical Evandra to use to some any Injury or other traumatic event, the Medical Evandra to the source of th 1 ☐Yes 2X No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5852 Brook Street 21801 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1944-1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 1944 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ward Harrington ည Nellie Hastings 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Linda Harrington - Wife</u> 5852 Brook Street, Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Pk. 11-20-2008 | Salisbury, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rganic /Medical Due to (r as a consequence of): Examiner Phagia Sequentially list conditions, Examiner Duis to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran lar KID SON Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown Completed cate has t page 2 sl 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 22 Ho certificate 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 D Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and (tile of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Harrington

5-0036

altimore, Maryland 2121

Division of Vital Records, P.O. Box 68760,

illiam

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39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)
NOV 1 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** RICHARD NOVEMBER 2008 /Medical SR HIMES 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL FREDERICK FREDERICK
If Under 1 Year | If Under 24 Hrs. HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Year) April 27, 19 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 213-24-7636 77 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show in than "natural", or items 23a or 28a-f show Middletown Director Maryland Frederick 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21769 United States 511 West Main Street Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or ite 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. White þ Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Street Cleaner City Government 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Flo Carmack Paul E. Himes ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 West Main Street, Middletown, Maryland 21769 Doris Himes / Daughter Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot November 25. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Monrovia, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final provic Obstructive Pulmonary Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a nonsequence of) The law requires that the death certificate be executed ng physician and as the burial-transit Exami Due to (or as a consequence of) Box 68760. Physician/Medical the attending p hed for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. I n signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1 □ Yes Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To funeral To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

eigh Williams

D0064741

Frederick Memorial Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 25, 2008 Physician G. Harrison 1425 M MARY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Homewood at Crumland Farms Frederick If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day OCt. 29 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year 1915 Maryland 1□ M 2 F 215-20-8853 93 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 28e-f ehow other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Maryland Frederick Frederick Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21701 U.S.A. 9 West 12th Street or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√ No Specify: Specify: White þ 3√2 Widowed 4 □ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Heelth and Mental Hygiens. Important: If Itam 27 is marked other than "na eny Injury or other treumatic event, Ita Madia 2008. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsie G. Heffner Leslie G. Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 70 Apple Cross Road. Harpers Ferry, W VA 25425 Thomas A. Disque, Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Reformed Cemetery Nov. 29, 2008 Jefferson, MD 21. Signa ou of Funeral Service Li 22. Name and Address of Facility Reeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one of ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Physician heart /Medical Due to (or as a consequence of): Examiner COTONALY ar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons-Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause ol death? 24a. Was an performe 2D No 1 ☐ Yes 2 No After this certification funeral director, p 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 ☐ Suicide in by 1 Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours efter To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO0 55061 November 26, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aubrie J. Nagy, M.D., 300 West Ninth Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 4 2008

DHMH 17 Rev 1/200

Registrar

physician as: man Hannison

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 2008 ALTHELIA ${ t MABEL}$ HEDGES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CHAR <u>'</u>_ If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F 214-32-8947 Director JUNE 8,1917 VIRGINIA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Funeral Director MD CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? OAK ROAD 20640 S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 ₩ Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than Hygiene. 3 JOME MAKEL OWN HOME Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mental JAMES HEDGES RUTH ARRINGTON မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOTTIE E. PATTERSON/DAUGHTER 3021 MOSS HILL ST.ZEPHYR HILLS, FL 33543 of Health Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Important: If It any Injury or c once. Burial 2 Cremation 3 Removal from State permit. Page Department TRINITY MEM.GRDNS. 26,2008 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. Signature of Funeral Service License ery Sou M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FEN IR disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' certificate 1 ☐Yes 2 ☐ No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours a 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

ASHVINKUMAR 31. Date filed (Month, Day, Year)
DEC 0 3 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATEL MUD 32. Rigistrar's Signature

2008

102 PAUL METTON CT WALDORF MD 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#30perDVR, G886, 12/3,08 WS.
State of Maryland Department of Health and Mental Hygiene amend #5, 17&18 Per FH G886 12/22/08 JH
Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Linda Hadley Lou November 21 2008 5:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Western Maryland Hospital Center Hagerstown 5 Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🕊 F Director 216-60-3842 May 5, 1953 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Exeminer must be notified at 1 Yes 2 No Director Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itame 23a 12013 Heather Dr. 21740 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Repairperson Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be la markad o Rowland Annabe11 Louise Myerly 2 Chester Roland Hadley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 417 Bethlehem Ct. Hagerstown Maryland 21740 Hadley / sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State jo = Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 11/26/2008 Hagerstown, Maryland Rest Haven Cemetery 22. Name and Address of Facility Rest haven Funeral Chapel 21. Signature of Funeral Service Censee 1601 Pennsylvania Ave. Hagerstown, Maryland 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final abeter **Physician** Mall disease or condition resulting in death) ye /Medical Due to (or as a consequence of) Examiner nd Stay Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit or Attending Physiclan: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy Se 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ ★6 Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 240 Division of Vital After this certific tuneral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending To the Hoapital or Attendinition 24 hours after death.

To the Funaral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suncide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

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State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Datta M.D.

- Patt MD

2008

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

gosta 32. Registrar's Signature

21/ D18019 DB

29d. Date signed (Month, Day, Year)

1500 Pennsylvania Avenue Hagerstown, MD 21742

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician NOV 2008 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex Cambridge If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Min. 18-44-6064 Months Days Hours 6 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Madical Expressions count by malified at 1 PYes 2 No Funeral Director HUrlock 10e. Street and Number 10g. Citizen of What Country? Village U5A 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 [X] No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Yes 2 Notes 1 Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced lack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be Lillian JOHNSON မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80239 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and : Department of Health Important: If Item 27 any Injury or other tro Green Valley Ranch Blvd. Denver Colorado

Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 11/19/08 Midshore Cremation 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY FUNERAL HOME, P. A.
510 Washington St. Cambridge, MD. 21613 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ditecer End Physician /Medical Due to (or as a consequence Examiner End if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à REERO. 1 ☐ Yes 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □Yes 2 00 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury a∜ Work? Natural Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

DHMH 17 Rev 1/2001

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

MD

32. Registrar's Signature

BYRN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

503

THANKY

29c. License number

29d. Date signed (Month, Day, Year)

11-21-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month NOVEMBER Dav Year **Physician** LOYNES 2045 0 13 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner OLINS HOPKINS BAYLLEW MEDICAL BALTIMOKE CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 216-70-633 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□ M 2□ F Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10h Town or Location 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, It a Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 102 19 Mother's Name (First, Middle, Maiden Surhame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 17. Fether's Name (First, Middle, Last) Be 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Bennie Smith Funcial Home aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart f Immediate Cause (inal disease or condition resulting in death) INTRACRANIAL Physician ELEVATED HOURS /Medical Due to (or as a consequence of): Examiner TUMOR f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of): Box 68760, physician by Physician/Medical IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) o. detached the 9 I Unknown Ū. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, pe 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h performed 2 X No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Tyes investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 DO LUCE raline 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMONE MA MiD GRAEME WOODUNTH 4940 ESTERN

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) NOV 18

32. Régistrar's Signature

2008

71				p. 100 1 11 0/2	177
State of Mar	vland / Departme	nt of Health	and Menta	I Hygierfe	U

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 8:00 A M Jones 18 2008 <u>Charlotte</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5363 Cherry Hill Lane Salisbury Inder 1 Year | If U Wicomico If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 2-8-1942 Director 66 218-40-6196 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Exactings must be notified at 1 Yes 2X No Director MD Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 death with items 23a 5363 Cherry Hill 21801 Lane Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or item any injury or other treumatic event, the Medical Exerci-Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: 2 If Yes, Give Year or Dates: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert ပ Clara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hartzell Jones - Nephew 27020 Riverside Drive, Salisbury, Maryland 21801 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 11-18-2008 Delmar, Delaware 22. Name and Address of Facility
Bounds Funeral Home 21. Signature of Funeral Service Licenses 705 E. Main Street, Salisbury, Maryland 21804 23a. Pavil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final Thilust 84 Divata Physician disease or condition resulting in death) /Medical Due to (c as a consequence of Examiner GNCW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the attending physicien and shed for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No let or Attending Physician: T s after death. In Director: After this certificat ad in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and editess of person who completed cause of death (Item 23a) (Type, Print) Justinian Ngaiza, 145 E. Carroll Street, Salisbury, MD 21801 31. Date filed (Month, Day, Year) State NOV 1 8 2008 Registrar

ohn Keplinger,	Jr.	State of Sta		Departme	ent of Health an ate of Death		lygiene	. No. 20	08 3872	
Physici Medical Exam		Decedent's Name (First, Middle,Last) John Kepling				SW I	2. Date of Death Month November		3. Time of Death 1306 hrs	
		4a. Facility Name (if not institution, give			4b. City, Town, or Cambridge	and the second second		4c. County of Dea Dorchester	th	
Funeral Director		5. Social Security Number 6Set 215–26–4952 X Usual Residence of Decedent	7. Age	(In yrs. last birth	Yrs. If Under 1 Year Months Day			(MM/DD/YYYY) 9. B 7 1930 Fore		
faryland 28a-f show any	or	10a. State 10b. County MD Dorche	T.	10c. City, Town	or Location Cambr	idge			10d. Inside City Limits 1 X Yes 2 No	
th the Maryfand 23a or 28a-f sho	Director	10e. Street and Number 124 Vue de Leau	Street		10f. Zip Code	21613	100	g. Citizen of What Country? USA		
hours after death with the Maryfand natural", or items 23a or 28a-f she Examiner must be notified at once	by Funeral		If Yes, Give Year 194	_{No} 49–52	13. Was Decedent of His If Yes, specify Cubar	n, Mexican, Puert	o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
54 2 -	Completed	15. Decedent's Education (Specify online Elementary/Secondary (0-12)	y highest grade comp College (1-4 or 5		Decedent's Usual Occupa during most of working life teacher			16b. Kind of Business public		
MD 21215-0036 d 2 should be filed within 7 tht and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Be	17. Father's Name (First, Middle, Last) John Keplinger				Lydia	e (First, Middle, Ma Scherch			
	Parametrice Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R Auth Galbraith sister 404 Douglas Avenue, C									
Baltimore, MD 2 permit Pages I and 2 shou Department of Health and Important: If them 27 is r injury or other traumatic		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:		te cremato	f Disposition (Name of ce bry or other place) and Veterans	Cem 11	20c. Location - City of Hurlock	, MD		
		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P 700 Locust St., Cambridge, MD 2161. 23a. Parl I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart								
Physician /Medical xaminer		failure. List only one cause on each Immediate Cause (Final disease a		Cardiovascul		, suçir as cardiac	or respiratory arres	it, Shock, or neart	Approximate Interval Between Onset and Death	
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s, P.O. B nires that the d signed by the		Part II. Other significant conditions		but not resulting	in the underlying cause	given in Part I.	1	acco use contribute to	o the cause of death?	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the stater death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed by						24a. Was an autopsy perform 1 Yes 2	prior to death?	per research p	
Vital Rec ysician: The his certificate	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatien	nt 2 ER/Qu		Other Nursi		esidence 6 🗸 Oth	er: Scene	
on of Vircuding Physicath. or: After this he funeral dir		1 V Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day,Ye	y 28b. T	ime of Injury 28c. Inju	ry at Work? Yes 2 No		w injury occurred		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide	28e Place of Init	ury - At home, far	rm, street, factory, office t	ouilding, etc.	28f. Location (Str or Town, Sta		tural Route Number, City	
To the Host within 24 ho To the Func completely f	Medical C	one) 2 V Medical Examiner:			th occurred at the time, divestigation, in my opinior					
	M	29b. Signature and title of certifier Women The	Ynee		29c. Licens		i i	29d. Date signed <i>(M</i> November 16, 2		
γ_{\star}		 Name and address of person who community Margarita Korell MD. Ass 	ompleted cause of de sistant Medical E		111 Penn Street, B	altimore, MD	21201			
St	ate	31. Date filed (Month, Day, Year)	32. egistrar	s Signature	1 4.					

	Physici /Medic		Marianna Deri	18 2008	3. 1111 O Death					
b	Examin		4a. Facility Name (If not institution, giv Vindobona Nurs			4b. City, Town, or	r Location of Dear		4c. County of Deat	
William C	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. In			If Under 24 Hrs Hours Min	8. Date of Birth		nplace (State or Foreign
ada. 1	Director		216-22-9058 13 Usual Residence of Decedent	□M 25xF 80	Yrs.		17,52,5	2/19/19	928 M) //
	yland now at		10a. State 10b. County	10c. City	, Town or Lo					10d. Inside City Limits
	e Mar 3a-f sh tiffed	Director	MD Frede	rick	Mid	dletown				1XYes 2 No
	with th		10e. Street and Number 8 Linden Blvd	i •		10f. Zip Code	769	109	g. Citizen of What Co USA	
	The purpose of the pu							14. Race - Ame Black, White	ican Indian,	
30										
215-0036	72 hou natura lical E	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working							b. Kind of Business/	ndustry
		Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		kind of work done of NOT use retired	d) most of we		uhlia a	ahaala
Z	Hyge Hyge	ဝင္ပ	17. Father's Name (First, Middle, Last		L(eacher	18. Mother's Na	me (First, Middle, Ma	oublic so	enools
yland	uld be Mental rrked o	To Be	George Mill	lard Derr			Elsie	Virgini	ia Holter	:
Mary	ges 1 and 2 should I t of Health and Men If item 27 is marked or other traumatic		19a. Informant's Name/Relationship (**					City or Town, State, Z	
<u>ရ</u> ်	1 and Health tem 27		Dwight Koogle 20a. Method of Disposition	20b. PI	ace of Dispos	sition (Name of	1		Letown, N	
	Pa Int:		P Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other Specif	Hemoval from State + .		natory or other place n Cemete		21/2008	Middleto	own, MD
Ball	permit. Departr Imports any inju		21. Signature of Pun Val Perviol Dice	19'ee	22	Name and Addre	ss of Facility B. Thom	npson Fur	neral Hon	ne
			110-11	olications that caused the death one cause on each line.						Approximate Interval Between
	Physician		Immedia Cause Final disease or con ition	Den	entio	υ				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	to the	Dila.			DAYS
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a consequ			00			y1. (0
	ecuted and -transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	ones of					741
08/0 0 ,	death certificate be executed e attending physician and d for use as the burial-transit			Due to (or as a consequ	ence oi).					
200	ertificat ing phy e as th	sician/Medical	IF FEMALE:							
POX	eath ce attend for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	1		23d. Date of deli Month	very Day Year
	g o	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	74(II)	Tottler (specify)				
λ, T	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	ontributing to death but not resu	Iting in the ur	nderlying cause give	en in Part I.	100	cco use contribute to	
	requir been si hould							1 Tyes		obably 4 □Unknown
i e	e las has je 2	ompleted				· · · · · · · · · · · · · · · · · · ·		24a. Was an autopsy performe	ed? death?	topsy findings available ompletion of cause of
	siclan: Th certificate rector, pag	e C	25. Was case referred to medical				26. Place of De	1 Yes 2[ath (Check only one)	□No 1□Yes	2□ No
0 0	di is	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E			4 Li Nursing i		ce 6 □Other (Spec	ify)
_	fe fe	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe how	injury occurred	
VISION	al or Attending s after death. Il Director: After d in by the fune	ertification:	3 Suicide 6 Could not be determined	e con Diego of injury. At hos	me, farm, stre			28f. Location (Stre City or Town,	et and Number or Ru	ral Route Number,
5	oltat or urs afte eral Di	0		0						
	e Hosi 124 ho e Fune letely f	edical	29a. Certifier (Check only one) 1 Certifying Pr 2 Medical Exam	nysician: To the best of my know miner: On the basis of examinati and manner stated.	ion and/or in	restigation, in my o	ne, date and place opinion, death occ	e, and due to the cau curred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier			29c. Licens		290	d. Date signed (Month	, Day, Year)
)	0				00-1/=	P 001	blils		11/19/08	
,	8		30. Name and address of person who	NUM_ TO 196	TT /	LOE, A	PREDERIG	CK, MO	21702	
100	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	houst s				

08-08952	
Glen Kreppel	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ien Kreppei	1- For State	Certificate of Death	Reg. No.	8 3872
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
ledical Examiner	Glen Robert Kreppel 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Month Day Year November 28, 2008	1845 hrs
	Atlantic General Hospital	Berlin	Worcester	
Funeral		Months Days Hours Min	8. Date of Birth(MM/DD/YYYY) 9. Bir Foreig	ın
Director	214-94-9633 1 X M 2 F 4	44 Yrs.	4/8/1964 ^{co}	untry) MD
S y		oc. City, Town or Location		10d. Inside City Limits
land f show an ource.	MD Worcester	Berlin		1 Yes 2 X No
the Maryland a or 28a-f show any tiffed at once. Director	11022 Charles Charles Dra	10f. Zip Code 21811	10g. Citizen of What Cou	ntry?
with the is 23a of enotif	11932 Grays Creek Dr. 11. Marital Status 12. Was Decedent Ev	ver in U.S. 13. Was Decedent of Hispanic Origin? (Sp		ican Indian, Black,
r death with or items 23 must be no	1 Never Married 2 X Married Armed Forces? 1 Yes 2			1. * 1
nral",	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 X No specify: eted) 16a. Decedent's Usual Occupation (Give kind of		white Industry
036 rithin 72 hour ar than "natu dedical Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life, DO NOT use ret		
within giene. her that the ompl		Commercial Diver	Diving e (First, Middle, Maiden Surname)	
21215-0036 old be filed within 7 Mental Hygiene. marked other than e event, the Medica	John F. Kreppel, Sr.		Joan Dorsey	
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State	
, MD and 2 sho calth and em 27 is raumati	Tammy Kreppel / wife	11932 Grays Creek Dr 20b. Place of Disposition (Name of cemetery,	., Berlin, MD 2181 Date 20c. Location - City or	Town, State
Baltimore, permit, Pages Lar Department of Hee Important: If iteninjury or other tr	1 Burial 2 XCremation 3 Removal from State	crematory or other place) Cape Henlopen Crem. 12	/3/2008 Frankford	DE
altin mit.; Pa partmer portan	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name and Address of Facility Bu	rbage Funeral Home	, 02
ii. II De iii.	With Bulal	l 108 William St	Berlin, MD 21811	Approximate Interval
Physician /Medical	23a. Part I. Enter the disease or complications that claused the failure. List only one cause on each line.		or respiratory arrest, shock, or heart	Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. <u>Cocăine il</u> Due to (or as a consequ			
<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	uence of):		
ed nsit Examine	cause. Enter Underlying Cause (Disease or injury that initiated			
uted nd ransit	events resulting in death) Lost			
be exectician audician X UNPENDED AMENDED 23a IF FEMALE: 23c. If yes, outcome	,PII,27,28a-f, permE, G887	1/14/09 TT		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit parties of Cortification: To Be Commleted by Physician/Medical Exhalical Certification: To Be Commleted by Physician/Medical Exhalical Certification: To Be Commleted by Physician/Medical Exhalical Certification: To Be Commleted by Physician Certification and Certification a	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the 1 Live birth	of pregnancy Fetal death 3 Ectopic pregn	23d. Date of deliver	ry Day Ye ar
). Box 687 the death certific by the attending p ched for use as th	past 12 months? 4 Pregnant at tin			
o. O. Be that the de detached for Physics	Part II. Other significant conditions contributing to death b	out not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
ires that the signed by it be detached	Atherosclerotic cardiova	scular disease	1 Yes 2 No 3 Pro	bably 4 Unknown
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Reco			1 Y Yes 2 No 1 Y Y	res 2 No
Tital Rec sician: The s certificate irector, page	25. Was case referred to medical examiner? Hospital: 1 Inpution	26.Place of Death (Check 2 ✓ ER/Outpatient 3 DOA Other Nursi	ing Home 5 Residence 6 Othe	
n of Vilding Physic After this funeral dir	27. Manner of Death 28a. Date of Injury		28d. Describe how injury occurred	
sion trendii death. ctor: A y the fu	1 Natural 5 Pending FD 11/28	/08 FD 6:03 pm 1 Yes 2X No	unk	
Division of Vital Records, spital or Attending Physician: The law requirement of the death of the death of the death of the death of the funeral director. After this certificate has been signed in by the funeral director, page 2 should be Completed Cartification. To Be Completed	3 Suicide 6 X Could not be determined (Specify) Hou	ry - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State) 11932 Gr Berlin, MD	ays Creek D
To the Hospital Within 24 hours. To the Funeral completely filled	1 29a. Cerimer	knowledge, death occurred at the time, date and place, an	d due to the cause(s) and manner as sta	ated.
To the Hos within 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examinand manner stated.	nation and/or investigation, in my opinion, death occurred 29c. License number	at the time, date and place, and due to t	
_ 2	29b. Signature and title of certifier	O.C.M.E.	November 29, 2	
	30. Name and address of person who completed cause of dea		<u></u>	
	Margarita Korell MD. Assistant Medical E	xaminer 111 Penn Street, Baltimore, MD	21201	
Stat	31. Date filed (Month, Day, Year) 32. Redistrar's	s Signature		

			for State	State of Maryla			d Mental Hygie	ene	
			Registrar		Certific	ate of Death		-No.2008	38724
	Physic /Medi		1. Decedent's Name (First, Middle, Las.	Win F	reene		2. Date of Death Month	Day Year	3. Time of Death
	Examir	ner	4a. Facility Name (If not institution, give	street and number) X Mb//b/ /	Panker 4b. C	ity, Town, or Location of De	eath	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Se	port - Lo	a. last birthday) If Ur Yrs. Mont	der 1 Year If Under 24 F hs Days Hours M	Ars. 8. Date of Birth in. May 7;		place (State or Foreign
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examinar must be redified at	Funeral Director	10a. State 10b. County 10e. Street and Number.	vico F	ity, Town or Location	nd Zip Code	100	, Citizen of What Cou	10d. Inside City Limits 1
	23a or	ralD	200 Pine	Street		21826	108	USA	nuy:
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examination and the refilled at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Ares 2 □ No If Yes, Give Year or Dates:		cedent of Hispanic Origin? specify Cuban, Mexican, Pu s 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White, Specify: B	
Maryland 21215-0036	vithin 72 h sne. :han "natu s Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's L (Give kind of life. DO NO	Isual Occupation work done during most of v T use retired)	vorking 16	b. Kind of Business/In	dustry
and 2	be filed v ntal Hygie ed other t event, In	Be	17. Father's Name (First, Middle, Last)	chan	Maarie	18. Mother's N	lame (First, Middle, Ma	iden Surname)	TOPESIONE
aryla	should and Me s mark umatic	P.	19a. Informant's Name/Relationship (7)	pe. Print) Wife	19b. Mailing Addr	ess (Street and Number or	Rural Route Number, C	ity or Town, State, Zig	Code)
re,⊠	s 1 and 2 f Health item 27 i		20a. Method of Disposition	20b.	Place of Disposition (SM St. T	ruitlana	p. Location - City or To	21826
Baltimore,	nit. Page artment o ortant: If injury or		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Fune 15 cell ens	lemoval from State	emetery, crematory of	' A 1	V. 22.08 +	ur lock.	, MD
	permi Depar Impo any ir	/	MA	10,8.	Bennie	0 10	me am w.	TSBUK SY	•
200-	Physician		23a. Part 1. Softer the disease, or complete shock, or neart failure. List only of Immediate Cause (Final	cations that caused the dea ne cause on each line.	th. Do not enter the n	node of dying, such as card	iac or respiratory arrest	,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consec		Tare Co			
ĝr .	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):				
60,	ficate be executed physician and sthe burial-transit		that initiated events resulting in death) Last	Due to (or as a consec	juence of):				
	rtificate ng physi as the t	Nedical	IF FEMALE.						
.O. Box	the death certifi by the attending pached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗆 Ectopi	c pregnancy (specify)		23d. Date of delive Month	ery Day Year
Records, P.	The law requires that the drate has been signed by the page 2 should be detached		Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobac	co use contribute to th	
Vital Rec	Ine la ate has age 2	• Completed	25. Was case referred to medical				24a. Was an autopsy performed 1 ☐ Yes 2, €	prior to cor death?	psy findings available inpletion of cause of
<u> </u>	lysician; lis certific director,	o Be	examiner?	ospital:	ER/Outpatient 3 🗆	Othori	eath (Check only one) Home 5 \[\subseteq \text{Residence}	6 DOthor (0)	
0 0	ding Fn h. After th funeral	On: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how i		()
Division of	or en coppinal or Attending Physician; within 24 hours after death, To the Furhours after death, completely filled in by the funeral director, p	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	M ome, farm, street, factory)	1 □ Yes 2 □ No ory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
	le Hospita 1 24 hours e Funera letely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best of my knoter: On the basis of examination and manner stated.	wledge, death occurration and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the caus curred at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
4	within To th comp	Me	29b. Signature and title of certifier		2	9c. License number	29d.	Date signed (Month, I	Day, Year)
	218		30. Name and accress of person who co	mpleted cause of death (Iten	n 23a) (Tuno Brint)	DA9105		11/12/08	
	J		Christijohn Hu	deteston 1	BDE. Can	roll St. Sal	Bbm, md	21801	
	Stat Registra		31. Date filed (Month, Day, Year) NOV 1 8 20	32. Registrar's Signa	ture Angul	4			

DHMH 17 Rev 1/2001

Analle

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

38725

	Registrar			Certificate of Death	Re
ysician Medical	1. Decedent's Name (First, Mic	J •	KIRK		2. Date of Death Month NOVEMB
	4a. Facility Name (If not institut	tion, give street an	d number)	4b. City, Town, or Location of Deat	h

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

✓

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Registrar				C	ertificate of	Death		Reg. No	100	0016
ian	1. Decedent's Name		le, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
cal	LEATRI		J.	KIR	K				BER 25		12:15P
ner	4a. Facility Name (/		-				or Location of D	eath		y of Death	n C
_	5. Social Security N		ICTORIA 6. Sex		vrs. last birthda	NEWE		Hrs. 8. Date of Bir	th	HARL 9. Birthr	LS place (State or Forei
			1 □ M 3€		Yrs	Months Days		Min. (Month, Da	ı <i>y, Year)</i>	Cour	SOURI
	493-20- Usual Residence of				_83			4,1925	FILS	BOORI	
١.	10a. State 10b. County 10c. City, Town or Location NEWF									1	0d. Inside City Limit
Stor	MD.		1 □ Yes 2 🔀								
ire	10e. Street and Nur					10f. Zip Code		10g. Citizen of What Country?			
<u></u>	10470	MT.V.	ICTORIA	ROAD		206	64		U.S.A	•	
Funeral Director	11. Marital Status		12. Was De	ecedent Ever Forces?	in U.S.	B. Was Decedent of If Yes, specify Cul	Hispanic Origin oan, Mexican, Pu	? (Specify Yes or No uerto Rican, etc.)	- 14. Ra	ce - Americ	
by Fu	1 Never Marri		ried 1 □Ye:	s 2 ∑ No Give		1 □ Yes 2 □ NO				fy: WH	
d b	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busines 16b. Kind of Busines 16c. DO NOT use retired 16c. DO NOT use retired 16c. DO NOT use retired 16c. DO NOT use retired 16c. NOT use re										
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ပ္	17. Father's Name	(First, Middle,	Last)				18. Mother's I	Name (First, Middle,	Maiden Surna	me)	
o Be	HENRY	McDO	NALD PO	WELL			BARBA	RA ELLE	N SWIT	ZER	
은	19a. Informant's Na	ame/Relations	ship (Type, Print)		19b. Ma	ilina Address (Stree	t and Number o	r Rural Route Numb	er. City or Town	n. State. Zin	Code)
			DAUGHTE	R	CMR			APO AE		,,	,
	20a. Method of Dis	position		2	0b. Place of Dis	position (Name of ematory or other pla	200)	Date	20c. Location	- City or To	own, State
	1 ☐ Burial 2 ☐	Cremation 5 Cother (5	3 ☐ Removal fro	m State	ROPOLI	TAN CREM	ATORY	12-2-08	ALEX.	,VA.	
	21. Signature of Fu					22. Name and Addr	ess of Facility	·			
	me	1	04		X	RAYMOND LA PLATA	FUNERA	L SERVI	CE, P.A	•	
	23a. Part 1. Enter t	he disease, or	r complications that only one cause or	t caused the	death. Do not	enter the mode of dy	ing, such as car	diac or respiratory a	rrest,		Approximate Interval Between
	Immediate Cause	(Final	Th	TRA(RAN	carly	- MA WA (ORHNO	Ne.		Onset and Death
	disease or conditio resulting in death)	""			nsequence of):			012(11)			× one / tex
		- 411	h								
Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or that initiated events	nations, mediate riving	Due t	to (or as a cor	nsequence of):						-
am	Cause (Disease or that initiated events	ińjury	с								
	resulting in death) t	Last	Due	to (or as a cor	nsequence of):						
dica			d								
n/Medical	IF FEMALE:		23c If yes	outcome of pr	egnancy						
ian	23b. Was deceden in the past 12	months?	1 ☐ Liv	ve birth 2☐ egnant at time	Fetal death	B	су			ate of delive Ionth	ery Day Year
ysi	1 □Yes 2) 9 □ Unknown			nknown	or dodin	JE Other (Specify)					
by Physicia	Part II. Other signif	ficant conditi	ons contributing to	death but no	t resulting in the	underlying cause g	ven in Part I.	23e. Did t	obacco use cor	ntribute to the	he cause of death?
								10	Yes 2 □ No	3□ Prob	pably 4 Unknow
Completed								24a. Was	an 24b.	Were auto	psy findings availab
шc				- · · · ·					rmed?	death?	mpletion of cause of
Be C	25. Was case refer	red to medica					26 Place of	1 ∐Yes Death (Check only o	20 No	1 □ Yes	2 LJ No
	examiner? 1 ☐ Yes 2 🙀	No	Hospital: 1 [☐ Inpatient	2 ER/Outpat	ient 3 □ DOA Ot	her	ng Home 5 Resi		her (Specif	fv)
T:u	27. Manner of Deat			ite of Injury onth, Day, Yea	28b. Time				how injury occu		2/
Certification: To	1 Natural 2 Accident		gation	, <i>Duy</i> , 100	,		Yes 2 □ No				
tific	3 ☐ Suicide 4 ☐ Homicide	6 □ Could detern	nined 286, Pla	ice of Injury - ilding, etc. (S	At home, farm, pecify)	street, factory, office		28f. Location (: City or To		ber or Rura	al Route Number,
Š											
ical	29a. Certifier (Check only	1 Certifying 2 ☐ Medical	Examiner: On the	e basis of exa	y knowledge, de mination and/or	ath occurred at the investigation, in my	time, date and p opinion, death c	lace, and due to the occurred at the time,	cause(s) and n date and place	nanner as s , and due to	stated. o the cause(s)
Medical	one) 29b. Signatur and		and m	anner stated.							
	290. Signature and) Certifie	- Kola	NI	ww	Zec. Lice	se number	624	29d. Date sign	7 7/	70 3
		/	1000	1	- Inneres			6 0 9	0	0'	
	30. Name and addr	ess of person	who completed ca	ause of death	(Item 23a) (Typ	e, Print)	1 Out	W. M	U. 2	206	03
ite	31. Date filed (Mon	th, Day. Year	32	. Registrar's S	Signature	0 00.	, , , , ,	1		- 0	
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rar		11 7 7 11	UO AMERICA	18 18	A PORT						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year RAY DAVID KING /Medical 2008 10:35A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Year) Days 12 M 2□ F Months Hours Min 72 216-30-3515 December 30, Director 1935 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at Director Maryland Frederick Frederick 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 7934 McKaig Road 21701 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ∏Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 10 1 ☐Yes 2 🔼 No White Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglens Important: If item 27 is marked other the any Injury or other traumatic event, it at once. 12 Meat Cutter and Manager Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray Singleton King Mildred Catherine Rippeon ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie King / Wife 7934 McKaig Road, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mount Olivet Cemetery 26, 2008 Frederick, Maryland 21. Signature of Funeral Se Reeney & Bastord P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leaf of the leaf Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy certificate perform 1 □ Yes 2 Mo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 110 1 / Impatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 No after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD66166 a 20 23 08 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myduscr 400 West Seventh Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) Registrar's Signature State nous . DEC 04 Registrar 2008

		_	For State Registrar	State of Ma			tificate o		h		Reg. N	00	0.8	3872	1
Г	Physicia	an	1. Decedent's Name (First, Middle, Las Edward Vincent	^{t)} Kelly						. Date of Do Month		2008	Year	3. Time of Death 2:15 P	М
	/Medic		4a. Facility Name (If not institution, give				4b. City, Towr	ı, or Locatio		10 1		c. County	of Death	2.17 1	
	Examin	CI	5900 Harwick Road				Bethes					Mont	gomer	У	
	Funeral Director		080-24-0354	7 14 0 D F	(In yrs. las 75	t birthday) Yrs.	If Under 1 Ye Months Day		er 24 Hrs. 8 Min. I	Date of Bi (Month, D eb.20	rth a <i>y, Yea</i>), 19	33	9. Birthp Cour New	place (State or Fore htry) York	ign
	and w t		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	cation						1	I 0d. Inside City Lim	its
	Mary I-f sho fied a	tor	MD. Montgome	ery		Beth	esda							¥∏Yes 2∏I	10
	th the or 28a e noti	Director	10e. Street and Number		·		10f. Zip Cod				10g. (Citizen of \		-	
	ath wi	rai	5900 Harwick Road					20816					S.A.	can Indian,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □X es 2 □ N If Yes, Give Year or Dates:		-	Was Decedent of Yes, specify C			ty Yes or N can, etc.)	0-		ck, White,		
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121	within ene. than '	Completed	Elementary(Secondary (0-12)	College (1-4or 5-	+)		ime Lob				L	abor	Unio	n	
9	filed Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)					18. Mo	ther's Name (i	First, Middle	e, Maid	en Surnan	ne)		
lan	Juid be Jenta rked ric ev	To B	Patrick Joseph Ke	≥11y				M	ary Noo	one					
ary	2 sho and N Is ma		19a. Informant's Name/Relationship (7				ailing Address (Street and Number or Rura				-			Code)	
	1 and Health Im 27 Ther to		Barbara S. Kelly 20a. Method of Disposition				900 Harwick Rd., Be							nwn State	
Baltimore,	ages int of h		1 Burial 2 ☐ Cremation 3 ☐	14 Burial 2 Cremation 3 Removal from State					ce of Disposition (Name of netery, crematory or other place) Date 20c. Location - City or Town, State Arlington, Va.						
Ħ	artme ortani Injury	i	21. Signature of Funeral Service Licen	-	Arii		Nation Name and Ad							va.	_
ñ	permi Depar Impol any ir	10. 1) Jenry & Fo	in l			222 Wis							D.C. 200	07
1	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused one cause on each line. a. Metasta Due to (or as a	tic T	ransi					arrest,			Approximate Interval Between Onset and Death 1 Year	
18	ecuted and running l-transit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):												
68760,	ifficate be executed g physician and as the burial-transit	edical E		.d											
Vital Records, P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	eath 3[Ectopic pregna Other (specify						ite of deliver	ery Day Year	
ds, P	juires that n signed b	by	Part II. Other significant conditions of Idiopathic Pul:	•			nderlying cause	given in Pa	rt I.					he cause of death? bably 4 □Unkno	
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ta	ilan: ertifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Pl	ace of Death (
<u>></u>	hysic this ce	To	1 ☐ Yes 2X No	Hospital:			IL 3 DOA		Nursing Home					fy)	
ž	ling P. After 1 funera		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	y Year) 2	8b. Time o Injury		njury at Work? I∐Yes 2	'	d. Describe	how in	ijury occur	red		
Division or	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			e, farm, sti	4717			f. Location City or To			ber or Run	al Route Number,	
	To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by	Medical C		ysician: To the best on the basis of and manner sta	examinatio										
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Lic	ense numb	er		29d.	Date signe	ed (Month,	Day, Year)	
			1 telen He	ann	n	W	D	320	533		No	ov. 1	7, 20)08	
	S		30. Name and address of person who of Peter G. Hamm, M	.D., 5530	Wisco	nsin	Ave.,#9	30, 0	Chevy C	hase,	Md.	. 208	15		
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	Logy	C.								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician Vincent E. Lania November 21, 2008 10:49A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Hospital Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours **№** M 2□ F 85 155-14-4305 Director Jan.30,1923 Italy Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Addical Examiner must be notified at 1

Yes 2 □ No Director Anne Arundel Maryland Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 627 Bay Green Drive 21012 U.S.A. within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married Married 1 ☐ Yes 2 No Specify: by White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Aviation Purchasing Agent permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carmelina DiBiase John Lania 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 627 Bay Green Drive, Arnold, Maryland21012 Rose Lania 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemi 11-25-08 East Hanover, N.J. 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licenses michae 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** aecliac /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): physician a the burial-1 Physician/Medical attending philosophia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) signed by the a d be detached f Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) rthis c Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide

P.O. Box 68760, Division of Vital Records, Hospital or Attending Physician: To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Baltimore, Maryland 21215-0036

State Registrar

8

Medical

29a, Certifier

(Check only one)

31. Date filed (Month)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death Item 23a) (Type, Print)

32. Registrar's signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

			for State Registrar		ryland / Depa <i>Ce</i>	artment of I rtificate of			ene g. No. 2008	38729	
	Physici	an	1. Decedent's Name (First, Middle, Last,)				2. Date of Death Month November		3. Time of Death	
100	/Medio		Marvin Paul Lynch 4a. Facility Name (If not institution, give	street and number)		4h City Town o	r Location of Dea		15, 2008 4c. County of Deat	6:15 A ^M	
+1	EXAIIII	er	Anne Arundel Medic	<i>'</i>		Annapolis			Anne Arundel		
	Funeral Director		340-07-0932	XX 2□F 88	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day,	9. Birt Year) Co 1920 I11	hplace (State or Foreign untry) inois	
	yland now		Usual Residence of Decedent 10a. State 10b. County	1.	10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Ba-f sh	Director	Maryland Anne An	rundel		Annapoli	.S			1 □ Yes 2X2XNo	
	3a or 2		10e. Street and Number 11 Brice Road			10f. Zip Code 21409			g. Citizen of What Co United Sta	,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Exemples must be rediffed at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ X Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ∑ Yes 2 ☐ No If Yes, Give	1942- 1946	Was Decedent of H If Yes, specify Cub: 1 □Yes XX No	dispanic Origin? (san, Mexican, Puer Specify:		14. Race - Ame Black, White	rican Indian,	
21215-0036	thin 72 hour e. an "natural Medical Ex	Completed t	15. Decedent's Edu (Specify only highest grade	Year or Dates: cation e completed) College (1-4or 5+)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking 1	6b. Kind of Business/	Industry	
21	led wit Hygien her th:	Con	12]	Plant Man		(=	Manufactu	ring	
altimore, Maryland	ould be fi Mental larked ot latic ever	To Be	17. Father's Name (First, Middle, Last) Robert John Lynch				Ilda Te	me (First, Middle, M nnessee D	ovey		
, Mar	and 2 sh ealth and 27 is m er traum		19a. Informant's Name/Relationship (Ty Linda A. Barbour /	· · · · · · · · · · · · · · · · · · ·					City or Town, State, 2 aryland 21		
nore	ages 1 ant of He tr. If item		20a. Method of Disposition 1 ☐ Burial ※ Cremation 3 ☐ P	Removal from State	20b. Place of Dispo cemetery, crer				Oc. Location - City or		
Baltir	permit. P Departme Importan any Injur		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lipe Service			2. Name and Addre	ss of Facility J	ohn M. Ta	Baltimore, ylor Funer Annapolis,	al Home,Inc	
	Physician /Medical	Vi. 1	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	. Ischemic	Colitis	er the mode of dyir	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death 4 Days	
أر	Examiner			Due to (or as a	consequence of):						
.0°,	ificate be executed g physician and is the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C								
68760,		edical		d							
.O. Box	law requires that the death certificate been signed by the aftending 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	cy		23d. Date of del Month	very Day Year	
ords, P.	w requires that s been signed b should be deta	ک	Part II. Other significant conditions cor Lung Cancer	ntributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	7.51	acco use contribute to	the cause of death?	
<u> </u>	The ate h	Completed	05 West and the first term of						prior to death? No 1 □ Yes	topsy findings available completion of cause of 2 □No	
		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ You	lospital:	2 ER/Outpatier	t 3 DOA Oth	or.	ath (Check only one)			
n 0	ding Phys h. After this funeral di	\vdash	27. Manner of Death XIX Natural 5 Pending	28a. Date of Injury (Month, Day,	28b. Time of			28d. Describe how	ce 6 Other (Spec	city)	
Division of		icatic	2 Accident Investigation 3 Suicide 6 Could not be		- At home, farm, stre	M 1 🗆	Yes 2 □ No	29f Location (Ct.)	A d Monte D		
2	ital or A irs after ral Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)			City or Town,			
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	siclan: To the best of ner: On the basis of eand manner state	xamination and/or in	n occurred at the til vestigation, in my o	me, date and plac opinion, death occ	e, and due to the car urred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)	
	Vithii To th	ž	29b. Signature and tipe of certifier			29c. Licens			d. Date signed (Month		
			30. Name and address of person who co	mpleted cause of dear	th (Item 23a) (Type	Print)	66753		u/17/	08	
teter.			Timothy M. C	11 stack mg	2001 M	edical Pa	tway.	Annapolis	Mo 2/11	1	
	Stat Registra		31. Date filed (Month, Day Year)	32. Registrar's	Signature	Carles	' '	V			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 14 Year .07 0 M Physician LeCates 14 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner MANOKIN V-Mne If Under 24 Hrs. MANO rincess 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Year) Hours Min. Days 1 □ M 2 🗓 F 8-16-1929 Director 79 213-22-5090 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be routified at once. 1 □Yes 2X No Director Salisbury Wicomico MD 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number USA 21801 1514 Riverside Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify. Specify: White \$ 3 ☐ Widowed 4 🕅 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Store Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Ε. E11a Larmore Α. ပ Alonzo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28150 Canterbury Drive, Salisbury, MD 21801 Sherry Tingle - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial Pk.: 11-18-08 |Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E. Main Street, Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Facture to **Physician** Frire 4 WK /Medical Due to (or as a consequence of): Examiner 54lars Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner loyeaus asov is Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 20 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mary er of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, neral Director: A filled in by the fu

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Pages 1 and 2 ment of Health a

28a-f show

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital o within 24 hours aff To the Funeral Di

Medical

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALISBURY, MD 21804 1415 . S. DIVISION ST, NATESAN

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Do51359

29d. Date signed (Month, Day, Year)

November 17th 2008

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

who Nata

(Check only one)

32. Registrar's Signature

NOV 1 8 2008



Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Carmen Rosa Marshall 18 16:53 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinci Hospital 5. Social Security Number of Baltimo 15 altimose (1+ Baltimose 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours Min. 1 □ M 2 🗓 F 079-24-5542 April9,1929 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Y∏Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2813 Echodale Avenue 21214 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: Black 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Garment District Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Rosa Marie Booker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lloyd Marshall/Son 2813Echodale Avenue, Baltimore, Maryland21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sidbury Cemetery 11-26-08 Rocky Point, N.C. 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee muliall marguelle 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jrosepsis disease or condition resulting in death) week Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ussase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Dementia 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an Hypertension Parkinson= 1⊠Yes 2□No sease 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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r than "natural", or Items 23a or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, If a M any Once.

Baltimore, Maryland

P.O. Box 68760.

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Examine physician and the burial-transit Physician/Medical attending p signed by the a 2 cate has been a page 2 should Completed Be r

The law requires that the death certificate be executed this certificate Attending Physician:

funeral within 24 hours after death.

To the Funeral Director: After completely filled in by the funera

27. Manner of Death 5 ☐ Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 Suicide

determined

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

29c. License number MI

RES. 000

29d. Date signed (Month, Day, Year) November 18, 2008

30. Name and address of person who someleted cause of death (Item 23a) (Type, Print)

State Registrar

Certification:

Medical

Corlos Balt Juan 31. Date filed (Month, Day, Year)
DEC 0 4 2008

MD STRA 32. Registrar's Signature

Hospital of Baltimore

To the Hospital or A within 24 hours after To the Funeral Direc

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND_LTEM#7perFH,G886,12/4/08,Ws State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** THOMAS O. MATTHEWS Noc County of Death /Medical 4b. Cify, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ea ehab Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 7/14/7939 1**X**M 2□F 212-30-9289 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County MD Harford 1 □Yes 2 No Bel Air Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 612 Foxcroft Drive 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary A. Bull Thomas O. Matthews ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma A. Matthews/Wife 612 Foxcroft Drive, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Evans Eagle Crematory 11/25/08 Leola, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature di Funeral Service Ligensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Pyr1. Fr is the discusse, or time locations that caused that stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final COPD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy performe 1∐ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 24, 2008 Mo. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n Havrede Grace, MD 21078 Bergamin Lee, MD 669 Revolution St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 4 2008

DHMH 17 Rev 1/2001

3altimore, Maryland 21215-0036

P.O. Box 68760.

vision or Vital Records.

		For State Registrar	State of Maryland	-	ertment of He etificate of D			iene g. No. 2 A A 8	38733
Physicia /Medic	1 6	1. Decedent's Name (First, Middle, Last) Roscoe McClain					2. Date of Death Month 11	Day Year 18 2008	3. Time of Death 12:29P.M
Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or			4c. County of Death	
	ct	Fort Washington Ho		and thirtholous)	Fort Wa	shington	8. Date of Birth	Prince Ge	
Funeral Director		5. Social Security Number 6. Sex 1♥	7. Age (<i>In yrs. I</i> M 2□ F 68	Yrs.	Months Days	Hours Min.	(Month, Day, 10/3/19	Year) Cou	nplace (State or Foreign untry) AL
de Ce de de de		Usual Residence of Decedent					10/3/19	40	
arylan show d at	۲	10a. State 10b. County		, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the M. 28a-f notifie	Funeral Director	MD Prince Ge	eorge's Fo	rt Was	hington 10f. Zip Code		10	Og. Citizen of What Cou	
3a or	ā		_		20744				ŕ
death	nera	1918 Belfast Drive	2. Was Decedent Ever in U. Armed Forces?	S. 13.\	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spen	ecify Yes or No-	14. Race - Amer Black, White	ican Indian,
partitioner, Interpretation Z I Z I 35-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If time Z1 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 2 No If Yes, Give Year or Dates:	1	1 ☐ Yes 2X No	Specify:	riiodii, oto.j		lack
72 ho	Completed	15. Decedent's Educi (Specify only highest grade		16a. Deced	lent's Usual Occupa kind of work done di DO NOT use retired)	ition uring most of worki	ing i	16b. Kind of Business/I	ndustry
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Mary d 2 shou th and M 7 is mai		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Street a			City or Town, State, Z	ip Code)
E, IVI		Marie E. McClain/W		1918	Belfast	Drive, Fo		ington, MD	
ages 1 and of H		20a. Method of Disposition 1	emoval from State		sition (Name of natory or other place	4		20c. Location - City or	•
allimor rmit. Pages partment of portant: If it y injury or c		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Septice LiGense		rt Lin	coln . Name and Addres			Brentwood, d Funeral S	
Departing any irr		Just V- Sh	Melent					Springs, N	
E E		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death	n. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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/Medical / Examiner		resulting in death)	Due to (or as a consequ	ience of):		3			
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ertific ding p	(D)	IF FEMALE:	c. If yes, outcome pf pregna	ncv				Data of dollar	
box leath cer attendin for use	sician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	Day Year
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The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions contained to the significant contained to the significant contained to th		ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	oacco use contribute to es 2∏No 3∏ Pro	the cause of death? . obably 4 Unknown
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The la	mo						autops perform 1□ Yes 2	y prior to death? death? 2 M No 1 □ Yes	completion of cause of 2 ☐ No
r VII.all HEC ysician: The law is certificate has t director, page 2 s	Be C	25. Was case referred to medical examiner?				26. Place of Deat		•	
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dling F	ion:	27. Manny of Death 1 Matural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	rat :? Yes 2 □ No	28d. Describe ho	w injury occurred	
INISION OF i or Attending Phys after death. Director: After this i in by the funeral di	ficat	3 Suicide 6 Could not be	28e. Place of injury - At ho	me, farm, str				reet and Number or Ru	ıral Route Number,
Ltal or safter ai Direction to be din the	Certification:	4 ☐ Homicide determined	building, etc. (Specif	()			City or Town	, State)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely fi	Medical (ician: To the best of my kno ler: On the basis of examina and manner stated.						
To th withir To th	Me	29b. Signature and title of certification	7//		29c. License	number	29	9d. Date signed (Month	h, Day, Year)
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R 3		30. Name and address of person who col	44					-	· · · · · ·
Sta	to	Deepak Sachd 31. Date filed (Month, Day, Year)	eva MD 1	1711 I	Livingstor	n Road, F	t. Washi	ington, MD	20744
Registr		NOV 2 1 2008	32. Registrar's Signa	MARCH PARTY					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Meekins 2008 50 PM organ NOV. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Money Make Road TRappe
If Under 1 Year | If Under 24 Hrs. Ra 1607 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. Days 1 M 2 □ F 212-26-164 Marylano Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 XYes 2 No rappe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 Funeral 2. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ş 3 Widowed 4 □ Divorced 1953 White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mover Transportal essional 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fill Health and Mental Hem 27 is marked otl Bean Edna Norgan MEEKINS ٩ SR, 19a. Informant's me/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 2815 Money Make Rd. Trappe Meek 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State d Shore Cremation Cambridge, MD 14/68 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P. A. 510 Washington St. Cambridge, MD. 21613 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kancher ho Concer **Physician** 5 -nd 10 CQ disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trans and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ whown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? After this certificate funeral director, page 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Besidence 6 ☐ Other (Specify) 28b. Time of Injury 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 TAccident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

P.O. Box 68760, of Vital Records, or Attending Physician: Division Hospital

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3altimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral C

31. Date filed (Mo. State Registrar

NOMAN

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THAN WY



29c. License number

CAMBRIDGE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Catherine B. McCahill 2008 1:50 A M Nov. 14, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 👿 F 216-48-9847 61 Director 28,1947 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Arnold Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1131 Ferber Avenue 21012 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 🛣No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 XNo White Specify: ð Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) General Contractor Home Improvements 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen N. Bertha Anna Louise McDonald ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Joseph M. McCahill/ Husband Arnold, MD 21012 1131 Ferber Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 4 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 2008 Metro Crematory, INC. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Barrancod & Sons, P.A. Severna Park Funeral H 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cancer VIVIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred (Month, Day, Year) Injury

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

The law second process and the second process are a second process. After this certificate has been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the burnar transit. attending physician and for use as the burial-trans P.O. Box 68760. been signed by the should be detached Division of Vital Records, page 2 s ne Hospital o 124 hours af ie Funeral Di

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

within 2

Medical

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause

NOV 1 7 2008

29b. Signature and title of certifier

(Check only one)

of death (Item 23a) (Type, Print) Bertgate Rd. Annapolis, Md. egistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ai yiai iu	•	tificate of	Death	, ,	g. No.2 0 0 8	33736	
	Physici	an	1. Decedent's Name (First, Midd	lle, Last)					2. Date of Death Month	Dav Year	3. Time of Death	
	/Medic		KIMBERLY	ANNE	MCG	RAIL			NOVEMBE	R 16 2008	1 / / / A	
	Examir	ner	4a. Facility Name (If not institution FREDERICK MEM	- /	۸т		4b. City, Town, o	r Location of Death	4c. County of Death			
-			5. Social Security Number		e (In yrs. las	t hirthday)	If Under 1 Year		8 Date of Birth	FREDERIC		
ı	Funeral Director		217-13-0518 Usual Residence of Decedent	1 □ M 2 🛣 F	27	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 5,	Year) Cou	nplace (State or Foreign Intry) 1and	
	land ow		10a. State 10b. County	/	10c. City, 7	Town or Lo	cation				10d. Inside City Limits	
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	ems	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	ever in U.S.	13. V		lispanic Origin? (Spean, Mexican, Puerto		14. Race - Amer		
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$\frac{8}{5}$	2 should be n and Mental is marked or raumatic ev	은	Michael Edger M	cGrail				Theresa M				
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מ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		21. Signature of Funeral Service	n Der						Williams F Maryland	uneral Home 20872	
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×	certi nding ise a	N/C	IF FEMALE:	23c. If yes, outcome	of pregnancy	У				23d. Date of deliv	vor.v	
DOX	death atte	cial	23b. Was decedent pregnant in the past 12 months? 1 X Yes 2 □ No	1 X Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pregnanc Other (specify)	ey .		Month Month	Day Year	
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>	hysic nis ce direc	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	nt 2□ER	/Outpatien	t 3 DOA Oth			ce 6 ☐ Other (Spec	ify)	
5 =	ng Pl	Ë.	27. Manner of Death 1 ▼Natural 5 □ Pendin	28a. Date of Injui	ry 28	b. Time of Injury	28c. Injur Worl	y at	28d. Describe how		-	
NISIOI NISIOI	endi eath. or: A the fu	atic	2 Accident investi	igation				Yes 2□No				
Ĕ	or Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ry - At home :. (Specify)	e, farm, stre	et, factory, office	2	28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,	
ב	urs at ur		- M									
	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier (Check only one) 1 ☑ Certifyii 2 ☐ Medical	ng Physician: To the best of I Examiner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the tir	me, date and place, opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)	
	Vithi Com	Ž	29b. Signature and title of certifie	er			29c. Licens	e number	290	d. Date signed (Month,	Day, Year)	
	0						Don	67210	N	ovember 16	, 2008	
7	(11)		30. Name and address of person	who completed cause of de	eath (Item 23	Ba) (Type, F	Print)		1 111			
	~		Rohit Khirbat,	MD, 400 West	Seven	th St	reet, Fr	ederick,	Maryland	21701		
	Sta Registr		31. Date filed (Month, Day, Year)		r's Signature	K I	berli					
	Registr	वा	MUA T	9 2008	USI A		A. C.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** NANCY NOV. LEE MYERS 25 2008 1:20A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SOUTHERN MD HOSPITAL CENTER CLINTON PR.GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC . 2 , 1936 9. Birthplace (State or Foreign Country)
WASH., D.C. 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Min. 1 □ M 2 🔀 F 71 577-50-2294 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Mydical Expirity. ACCOKEEK MD. PRINCE GEORGES 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2707 HIDDEN VALLEY ROAD 20607 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EVERETTE HENRY STOWE VIRGIE MAE KIDWELL 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE W.MYERS, JR.-SPOUSE 2707 HIDDEN VALLEY RD. ACCOKEEK, MD. 20607 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Neurial 2 Cremation 3 Removal from State TRINITY MEM.GARDEN 11-28-08 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 21. Signature of Funeral Service Licensee M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final B-CELL LYMPHOMA **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.0. certificate has been signed by the a rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ HEPATIC FAILURE 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RENAL FAILURE autopsy performed? PANCREATIC MASS 2 No Division of Vital 1 ☐Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ∏Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Recistrar

31. Date filed (Month, Day, Year) State DEC 04 2008

HERBERT WASHINGTON, M.D.11701 Livingston Rd.Ft.Washington,MD20744 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D32800

NOVEMBER 25, 2008

08-08872

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Robert Samuel Mod		For State	St	ate of N	<i>l</i> laryland	d / Depar <i>Cert</i>	rtment of tificate of	Health Death	n and	Menta	al Hygie	ene Reg.	21	008	3 33 131
Physician/	Re	distrar Decedent's Name	(First, Midd	e,Last)			in out o					ate of Death		3.	Time of Death
Medical Examine	r	ROBER	T SA	MUEL	MOOR	E						ovember 2	5, 2008		2305 hrs
	4	a. Facility Name (if	not institution	n, give stre	et and numb	er)		4b. City, Town, or Location of Death Cheverly					4c. County of Prince Ge		
	Ļ	Prince Georg		6. Sex		Age (In yrs. la	st hirthday)	If Under		If Under	24Hrs. 8.	Date of Birth	(MM/DD/YYYY)	.g. Birthp	lace (State or Foreign
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215-0036 be filed within 72 hour ntal Hygiene. rked other than "nattent, the Medical Exam	<u> </u>	7. Father's Name	(First, Middle	e, Last)					1.	8.Mother's	Name (Fi	st, Middle, Ma	aiden Surname)		
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Itim iit. Pa artinen ortani	-	4 Donation 5 21. Signature of Fu	Other :	Specify: e_Licensee	M00		22.	Name and	Address	of Facility		- 27			
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8 £ 5 %		29a. Certifier 1	Certifying	Physician	To the bes	t of my knowle	dge, death oc	curred at th	ne time, d	ate and pl	lace, and d	ue to the caus	se(s) and manne and place, and	er as state due to th	ed. e cause(s)
Di To the Hospital . within 24 hours a To the Funeral I	Medical			_ar	n the basis o	tated.	anaror mvesti			se number					nth, Day, Year)
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo. November 26, 20								008						
		30. Name and ad	dress of per	son who cor	npleted caus	se of death (Ite	em 23a)								
6		Carol Allar			Medical	Examiner	111 Peni	Street	Baltim	nore, MI	D 21201				
Sta Registr		31, Date filed (Mc	onth, Day, Ye	ar) 008	32. Re	egistrar's Signa	ature 6	9							

State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar			Certif	ficate of	Death		Reg. N	<u> </u>	00100
	Physicia		1. Decedent's Name (First, Middle	, Last)					2. Date of D		ay Year	3. Time of Death
ŧ	/Medic		Duane	Karl	М	cClary			Nov.		*	11:16 p. M
	Examin	er	4a. Facility Name (If not institution			41	b. City, Town, or	r Location of D	eath	4	c. County of Dea	th
		# F	Washington Adve				Takoma	Park If Under 24 I	Um 10 D 1 10		lontgomer	
	Funeral	1	5. Social Security Number	1XIM 2□ F	(In yrs. last		lonths Days		lin. (Month, D	ay, Yea	r) Co	thplace (State or Foreign ountry)
	Director		216-88-4900 Usual Residence of Decedent	4	7				June 1	3, 1	1961 M	aryland
	land bw tt	-	10a. State 10b. County	-	10c. City, To	own or Locati	on					10d. Inside City Limits
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	the 28a	rec	10e. Street and Number	/IVania	rrede	ricksb	10f. Zip Code			10g. C	itizen of What Co	ountry?
	3a or	Funeral Director	3616 East Glen	Dower Drive			22408			US	SA	
	ms 2	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was	s Decedent of H	ispanic Origin	? (Specify Yes or Nuerto Rican, etc.)		14. Race - Ame	
9	after or ite	3	1 ☐ Never Married 2X Marri	ied 1 Yes 2 No			Yes 21 No	Specify:	derio nican, etc.)		Black, Whit	
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Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highest	's Education of grade completed)	11	6a. Decedent (Give kind	t's Usual Occup d of work done o NOT use retired	ation during most of	working		Kind of Business	•
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ρ	Pages nent of P int: If ite		1 X Burial 2 ☐ Cremation		Cerrie	stery, cremati	ory or orner plac	ie)				
3altimore,	it. Partme	-	4 ☐ Donation 5 ☐ Other (Single 21. Signature of Funeral Service)		Junia		n. Park ame and Addre		/29/2008	Lew	istown,	PA
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused to	he death. D	480	L Jett he mode of dvir	Davis F	WY Frede	rick	sburg, \	
			shock, or heart failure. List immediate Cause (Final	only one cause on each line	-0-	an	~ T=	12 3/10	OKI 12	-12.7	2000	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a			20/2	_ // 0/	WKI ZI	- U R	Noc	
	Examiner			Due to (or as a	consequen	ce oi).						
	¥	ē	Sequentially list conditions, if any, leading to immediate	b	consequen	ce of):						
by	uted d ansit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
13,	ertificate be executed ing physician and e as the burial-transit	Examiner	resulting in death) Last	Due to (or as a	consequen	ce of):						
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Box			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pt 1 ☐ Live birth 2			topic pregnancy	,		İ	23d. Date of de	livery
	deal	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at ti			ther (specify)	·			Month	Day Year
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ñ	ing	on:	27. Manno of Death 1 ☑ Natural 5 ☐ Pending	g 28a. Date of injury (Month, Day	Year) 28	b. Time of Injury	28c. Injur Wor		28d. Describe	how inj	ury occurred	
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Division or	or At offer of Direct in by	Certification:	4 ☐ Homicide determi		(Specify)	, iarrii, street,	ractory, office		City or To	(Street a wn, Sta	and Number or Ri te)	ural Route Number,
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	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Me	29b. Signature and title of certified		/		29c. Licens	e number	/	29d. D	ate signed (Mont	th, Day, Year)
	- > - 0		> //who	my //			nes	576	14	10	1/24/0	P
	a	-	30. Name and address of person	who completed cause of dea	ath (item 23	a) (Type, Prir	nt)	700	rus Pi	200	1 211	
	V		10		ROL	Ro	/ST.	11140	MA PI	FER	100	
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Sneath.	TO THE PARTY OF TH					
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State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marc D. Nicodemus 2008 3:00 A.M November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick 10748 Green Valley Road Union Bridge 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours 1 X M 2 □ F 45 214-48-4164 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any hjury or other traumatic excessions. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Director 1 ☐ Yes 2√☐ No Union Bridge Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21791 United States 10748 Green Valley Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: white Completed by 3 ☐ Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lab technician medical labs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard Grossnickle Nicodemus Mary Rice ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7508 Lovely Ct., Frederick, MD 21702 Leonard Nicodemus / father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ¹X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Gardens 11/28/08 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service Licensee Mul Clargeller MO1222 106 East Church Street, Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ADENOCARCINOMA **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immiscrate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Dus to for as a consequence off death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No detached 9 Unknown ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? After this certificate has page 2 performed 2 No 2 No 1 ☐ Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2½ZNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Jopital C.

4 hours after dec.

Therefore After a by the further and a second and a second a 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29c. License number 29d. Date signed (Mpnth, Day, Year) D31761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21701 FREDERICK SOI W. SEVENTH MO Dr. Brian O'Connor

State Registrar 31. Date filed (Month, Day, Year)

DFC 0 4

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3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#21perFH, G886, 12/3/08 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician Russel Eugene 2008 Ocker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 □ F Director 212-14-7010 90 Jan. 20, 1918 | Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nobical Expedient must be notified at Director 1XYes 2 ☐ No Maryland Washington Maugansville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17923 Eby 21767 Lane U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify. ģ Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Chemist Aircraft Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cyrus Russel 0cker ျှ Vesta Hause 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia J. Alsip / Daughter .O. Box 172 Maugansville Maryland 21767 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 11/26/2008 Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee S. Mark Scripp PER DVR 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami and burial-tra Division of Vital Records, P.O. Box 68760, attending physician for use as the buria law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Yea Pregnant at time of death 5 Other (specify) □Yes 2□No 4 ☐ Pregnant 9 ☐ Unknown the detached 9 Unknown þ signed I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy certificate 0 50 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After 1 Natural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 127898 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 350 HILL ST. Hagerstoney MD 21742 RANCISCO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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2008

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32. Registrar's Signature

#8. per Fh g886 12/15/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19, 2008 Month Day 9:16 PM **Physician** Evelyn Pollock Mae /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burnie Baltimore Washington Center Glen runde If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **1918** 9. Birthplace (State or Foreign July 30, 198 Pennsylvania 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 1 F 278-07-6625 90 July Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Eventual must be notified at once. 10a. State 1 ☐ Yes X☐ No Directo Anne Arundel Linthicum Heights Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 114 Kingbrook Road 21090 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Worker Public Utility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Sahli F.Sharp Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21090 19a. Informant's Name/Relationship (Type. Print) Kim Pollock Hudyma/Daughter 114Kingbrook Road, Linthicum Heights, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crown Hill Burial 11-24-08 Vienna, Ohio Fark Name and Address of Facility Marzullo Funeral Chapel, P. A. 21. Signature of Funeral Service Licensee michae 6009Harford Road, Baltimore, Maryland21214 Mer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Infavet Immediate Cause (Final ocava **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 2 1 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 Could not be 3 D Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c, License number 4136 Haspital Drive, Gen Burnie, 30. Name and address of person who completed cause of death (lear) 23a) (Type, Print)

Registrar

State

DVO 31. Date filed (Month, Day, Year)

DEC 0 4 2008

32. Registrar's Signature

2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per Phy G886 12/04 08 JH State of Maryland / Department of Health and Mental Hygiene amend #26 Per Phy Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2008 11 13 12:05P. William O. Price /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** 5601 Old Silver Hill Road Forestville Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min 1 X M 2 □ F Yrs. 9/11/1952 56 DC Director 578**-**74**-**0465 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r then "naturel", or Items 23a or 28a-f show The Medical Examiner must be notified at 1X Yes 2 No Funeral Director Prince George's Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20735 USA 4405 Natahala Dr. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Black Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Beverage Distributors Fountain Technician 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked othe any injury or other treumatic svent, sone. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary E. Bell 2 William B. Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent Price/Brother 4405 Natahala Dr., Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. 11/20/08 Brentwood, MD 21. Signature of Funeral Selvice Ul ensee 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Cardiac Arrhythmia /Medical Due to (or as a consequence of): **Examiner** Pulmonary Hypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Il-transit The law requires that the death certificate be executed Sleep Apnea Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day Year Month 5 Other (specify) 4□Pregnant at time of death o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 (X No 1 🗌 Yes 2 \(\text{No} 1 Yes Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Rooming Hospital: 1 🗌 Inpatient 2 ER/Outpatient 2 1 ☐ Yes 2 X No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours at To the Funeral D completely filled in 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner etated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D0031173 11/19/08 30. Name and address of person who completed cause of death (Item 23a) Types, Find Raymon K. Nelson, MD, 1160 Varnum St., #208, NE, Wash., DC 31. Date filed (Month, Day, Year) 32. Registrar's Sig State 2008 Registrar

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		For	State of Mar	•	•			/	38744		
		Registrar 1. Decedent's Name (First, Middle,	Logi		ertificate o		2. Date of Dea	Reg. No.	3. Time of Death		
Physici	an	Charles Frankl	·					er 10, 200	7:00 A		
/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town	, or Location of Dea		4c. County of De			
E AGIIIII		2040 Chesapeak	e Road		Ar	napolis		Anne A	rundel		
Funeral Director				In yrs. last birthd	Months Day				rthplace (State or Foreign Country) Maryland		
ъ		Usual Residence of Decedent		Oc. City, Town or	Location		Joepe .		10d. Inside City Limits		
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r 28a-	Funeral Director	10e. Street and Number			10f. Zip Code	e		10g. Citizen of What C	Country?		
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deat	ıner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 1	3. Was Decedent of	f Hispanic Origin? (uban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh			
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Id be lental rked o	To Be	William F. Poole	2			Edit	h D. Woos	ster			
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1 and 2 1 and 2 Health tem 27 i		Matilda Louise	Poole/Wife			-		olis, MD 21			
permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3			sposition (Name of crematory or other p		Date 13,	20c. Location - City o			
attimo		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		3-05:	garet's E	dress of Facility	2008	Annapolis	, MD		
Dermi Depar Impo any ir		X Shows ?	-211		Barranco	& Sons, E Ritchie E	P.A. Sev	erna Park erna Park,	Funeral Home		
		23a. Part 1. Enter the disease, or conshock, or heart failure. List of	omplications that caused that one cause on each line.					· · · · · · · · · · · · · · · · · · ·	Approximate Interval Between		
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Sicla s certi irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 Vo	Hospital:	2 ER/Outpa	tiont 3 🗆 DOA	Other:	eath (Check only o	<i>ne)</i> dence 6 □Other <i>(Sp</i>			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical E	Physician: To the best of xaminer: On the basis of e	xamination and/o	eath occurred at the r investigation, in m	e time, date and plac ny opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner date and place, and di	as stated. ue to the cause(s)		
thin 2.	Medical	29b. Signature and title of certifier	and manner state	d.	29c. Lice	ense number		29d. Date signed (Mor	nth. Day. Year)		
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GAL.	5	30. Name and address of person w	ho completed cause of dea	th (Item 23a) (Tvi	-						
in the same		Vidos Pl	avres 150	19 Kit	this b	Jhuy A	rnoll,	MD 2/1	112		
Sta Registr		31. Date filed (Month, Day, Year) NOV 1 4	2008 32 legistrar's	s Signature	beart.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-08744 State of Maryland / Department of Health and Mental Hygiene Timothy Pomeroy 2008 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day November 21, 2008 2136 hrs Medical Examiner Timothy Younger Pomeroy 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Pikesville 1721 Reisterstown Road, Room #110 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) Months Davs Hours .Min Director MD 1x M Yrs 2 F 217-02-0139 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Yes 2 XNo or 28a-f show 23a or 28a-f show notified at once. MD Carroll Westminster Director 10g. Citizen of What Country 10e Street and Number 21158 USA 423 Spalding Ct Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces Never Married is marked other than "natural", or iter atic event, the Medical Examiner must 2 X No Yes Specify: White Yes 2 X No specify: f Yes. Give Year Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) ore, MD 21215-0036
Is 1 and 2 should be filed within 72 has Health and Mental Hygiene. within 72 Carroll County Times Carrier 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sandra Tinkler Ralph Timothy Pomeroy æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 423 Spalding Ct. Westminster, MD Nicole Pomeroy/wife If item 27 of Health. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Itimore, 11/26/2008 crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Pages 1 tment o Meadow Branch Cemeter Westminster, Donation 5 Other Specif 'n 22 Prices Fineral Home and Chapel, P.A. Signature of Funeral Service Lice Westminster, MD t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Asphyxia 412 Washington Road 23a. Part I. Enter the disease, or complications Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): D.O. Box 68760, that the death certificate be executed 23a,27,28a-f, perm,E g886 12/9/08 TT Physician/Medical X UNPENDED X AMENDED attending physician or use as the burial -#26 per ME g886 12/30/08 TT 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the past 12 months? Day 3 Ectopic pregnancy Month Live birth Fetal death Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 Unknown ģ σ. Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed' death? certificate has Yes 2 V No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medica Division of Vital Be Other₄ Residence 6X Other: Hotel Room examiner? Hospital:, Nursing Home 5 DDA Inpatient 2 FR/Outpetient 1 Yes 28c. Injury at Work? 28d Describe how injury occurred subject intentionally inhaled 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Manner of Death Certification: Yes 2 X No Pending heli<u>um gas with plastic bag o</u> Fnd 11/21 /08Fnd 11:3 2 Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State), 1721 Reisters town Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide Could not be Hotel (Ramada Inn) determined (Specify) 110. Pikesville. Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 22, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 31. Date filed (Month, Day, Year 32. Registrar's Signature State 2008 MANE STATE DEACE NOV 2 2 Registra

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month **Physician** 1: 00AM **Pendergast** Elizabeth Marion /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 11229 Wabash Street, NW Cumberland Allegany 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Min. Months Days 1 □ M 2 □ F Aug 27, 1925 Director 216-22-7125 83 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at any Injury or other traumatic event, the Medical Examinar must be 1 ☐ Yes 2 ☐ No MD Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 11229 Wabash Street, NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 😿 Specify Specity: 2 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul H. Shaffer Angela E. Shaffer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11229 Wabash St. MD 21502 Patrick Pendergast husband Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Øremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 11/25/2008 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final disease or condition resulting in death) a. Approximate Interval Between Onset and Death **Physician** /Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specity) 9 Unknown **ber significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Trobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **1** No 25. Was case referred to medical examiner? 26. Place of Death (Check only ofte) Certification: To Be Other: 4 Nursing Home 5 Presidence 6 Other (Specity) 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1/2 Natural

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. F

5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 054411

State

Registrar

f person who completed cause of death (Item 23a) (Type, Pript)

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any loiury or other traumatic event, I've Modical Exemirer must be notified at once. Baltimore, Maryland 21215-0036

Physici /Medi Examir

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - State of Marylan	_	artment of Healt rtificate of Dea		-	jiene eg. No. (008	33	747	
	1. Decedent's Name (First, Middle, Last)		inodio or zon		2. Date of Dea			3. Time of	f Death	
an	Hallie V. Pot	ter			Novembe	r 23	2008	0815	АМ	
al	4a. Facility Name (If not institution, give street and number)		4b, City, Town, or Locati	on of Death	110 V CIMB C	1	nty of Death	0013	- A	
er	Union Hospital		E1kton	Ceci1						
	5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If Un	der 24 Hrs.	8. Date of Birth	1	9. Birth	place (State	or Foreign	
	218-34-1266 1□M 2MF 94	Yrs.	Months Days Hou	rs Min.	(Month, Day July 12		Ten:	^{ntry)} nessee		
	Usual Residence of Decedent				July 12	9 1714	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	HESSEE	·	
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irec	10e. Street and Number		10f. Zip Code		1	0g. Citizen o	of What Cour	ntry?		
무	87 Russell Road		21921		Unit	ed Sta	ates			
Jer	11 Marital Status 12. Was Decedent Ever in U.	S. 13. \	Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Spe	ecify Yes or No-	T	Race - Americ			
Ξ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No				Rican, etc.)	В	lack, White,	etc.		
by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1	1 □Yes 2 X No <i>Spe</i> e	cify:		Spe	cify: Wh	ite		
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e C	17. Father's Name (First, Middle, Last)		18. M	other's Name	(First, Middle, I	Maiden Surn	ame)			
To E	Hillary Lewis		F:	allie	Hampton					
_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street and Nu			r, City or Tou	vn, State, Zip	Code)		
	Doris Welch/Daughter	95 F	Russell Road	E1k+	on MD	21921				
	20a Method of Disposition 20b F	Place of Disno	sition (Name of	, D	ate	20c. Locatio	n - City or To	wn, State		
			natory or other place)	Novem		O.		Ver		
	4 Donation 5 Other (Specify) Methodist Cemetery 26, 2008 Cherry Hill, MD 21. Signature of Funeral Service Licensee 1 22. Name and Address of Facility									
	Hicks Home for Funerals, P.A.									
_	23a. Part1. Enter the disease, or complications that caused the deat						MD 21	.921 Approximat	te	
	shock, or heart failure. List only one cause on each line.				140	16		Interval Bet Onset and	tween	
	disease or condition resulting in death)	nic	Cor 011	010	YOPE	ZTV	Y	15y	27	
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ij	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1 5	Sindi=	ati	010			100	Ini	
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ian	in the past 12 months?	ideath 3	Ectopic pregnancy Other (specify)				Date of delive Month	,	Year	
ysi	1 ☐ Yes 2 ☐No 9 ☐ Unknown 9 ☐ Unknown	JC441 J L	Joiner (specify)							
윤	Part II. Other significant conditions contributing to death but not resi	ulting in the ur	nderlying cause given in Pa	art I.	23e. Did tol	pacco use co	ontribute to ti	ne cause of c	death?	
Be Completed by Physician/Me					1 □ Ye	es 2 134110	3 □ Prot	ably 4 🗆 I	Unknown	
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ď					24a. Was a autops perfori	n 241	b. Were auto prior to co	psy findings mpletion of c	available cause of	
Ŝ						2 No	death? 1 □ Yes	2 □No		
	25. Was case referred to medical examiner?			lace of Death	(Check only on	e)			-	
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on:	27. Manno of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work?		28d. Describe ho	w injury occ	urred	3		
cati	2 Accident investigation 3 Suicide 6 Could not be 289 Place of Injury - At be		M 1 □Yes 2	No						
Ħ	4 Homicide determined 28e. Place of Injury - At he building, etc. (Specific	ome, farm, stre y)	eet, factory, office	2	28f. Location <i>(Si</i> City or Towl	reet and Nui n, State)	mber or Rura	d Route Nurr	nber,	
පී										
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Examine: On the basis of examina and manner stated	wledge, death tion and/or in	n occurred at the time, dat vestigation, in my opinion,	e and place, death occurr	and due to the or red at the time, d	ause(s) and ate and plac	manner as s e, and due to	stated. o the cause(s	s)	
Med	and mariner stated,		20a Licence numb	ner .		Od Data si-	ned (Marth	Day Vos-1		
=	29b. Signature and title of certifier		29c. License numb	er .		9d. Date sig		-	000	
	Jose // Ules M.D.		DHHT	16	^	10.151	rper	23,3	2008	
	30. Name and address of person who completed cause of death (Iten	1 23a) (Type,	Print)	- v	MD -	192	1			
	Jose Ma III W. H.	By R	st, EIKI	WN 1	WA 3	177	. 1			
	Of Detailed (Manual Detailed of CO Desilet 1 C)									
te ar	31. Date filed (Month, Day, Year) DEC 0 3 2008 32. Registrar's Signa	ture								

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Sta

08-08611 Nancy S Quimby Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ancy S Quilliby	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2008	3874
Physiciar ledical Examin		
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c.	
Funeral.	University Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs: 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Str	ate or
Director	089-40-2235 1 M 2X F 61 Yrs. Months Days Hours Min. AUG. 08, 1947 Foreign NEW Country	YORK
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Maryland 28a-f show	MD TALBOT CORDOVA	s 2 X No
th the Maryland 23a or 28a-f sho notified at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
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hours aff	or Dates:	
136 thin 72 h than "n than "n	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) TEACHER 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER EDUCATION 17. Father's Name (First, Middle, Last)	
15-003 filed within Hygiene. d other th	12 5 TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
21215-0036 Uld be filed within 72 hours a Mental Hygene. marked other than "natura cevent, the Medical Examin	WALTER JAMES SORRELL THELMA BAILEY	
MD 21 d 2 should th and Me n 27 is ma umatic ex	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACKIE WILHELM/ DAUGHTER 643 POPLAR SCHOOL RD, CENTREVILLE, MD 21617	
re, N I and F Health f item er frau	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 X Cremation 3 Removal from State Crematory or other place) Date 20c. Location - City or Town, State Crematory or other place)	e
Baltimore, MD permit. Pages I and 2 sh Department of Health an Important: If item 27 is injury or other traumat	4 Donation 5 Other Specify: CHESAPEAKE CREMATORY 11-19-2008 STEVENSVILLE,	
Baltimore, MD 21215 permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked of injury or other traumatic event, if	22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617	P.A.
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart. Approxim	mate Interval n Onset and
xaminer		Death
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	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Uisease or injury that initiated	,
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x 68760, h certificate be ex ending physiciar use as the burial	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	
ox 687 sath certifice attending p	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (Specify)	Year
D. Boy t the deat by the att	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of	of death?
P.O.	1 Yes 2 ✓ No 3 Probably 4	
of Vital Records, ng Physician: The law require ther this certificate has been signeral director, page 2 should be	24a. Was an 24b. Were autopsy finding autopsy prior to completion	
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of Viiing Physi	27 Manager of Dooth	
sion trendin death. ctor: A	1 Natural 5 Pending Nov 11, 2008 1509 hrs 1 Yes 2 V No Driver auto auto collision	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Far hours after death. Refr. Mer this certificate has been signed by the attending physician and the fulled in by the intenst director, page 2 should be deached for use as the burial - transi	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Nor Town, State) (Specify) Local Street (Specify) Local Street	lumber, City
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the		
To To with	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye	ar)
12	Cer(1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,	
	30. Name and address of person who completed cause of death (Item 23a) \\ Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat		
Registra DHMH 17 Rev 1/200	ORIGINAL	
OCMF 2006	ORIGINAL	

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be ပ္

Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

1 ☐ Yes

29a. Certifier

detached

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Sarah Annette Rockwell <u>10:</u>35a[™] 2008 November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Manchester LongView Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🕱 🕏 025-20-5548 97 Dec 27 1910 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 □ No Manchester Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3332 Main St. 21074 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Historical Dioramist</u> Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William O. Layton Sarah Cahill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wallace Rockwell 375 Kingsbury Way #24 Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 11/17/08 Hampstead, Maryland 21. Signature of Funeral Service Ligensee Printendrumeraria Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer Dement Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No performed' 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

51705

Hestminster MD

CEW

State Registrar

DHMH 17 Rev 1/2001

malcolm 32. Regierrar's Signature

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

349

KUNDWU

M. PANSURIYA

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 05394M KICHARD NOVEMBER 14 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days 05/20/ 467-10-3957 95 1913 Texas Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location od 2 should be filed within 72 hours after death with the Marylan th and Mertal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Macter Eximiner must be notified at 1 Yes 2 □ No Directo Charles Waldorf Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 6192 Pronghorn Court 20603 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1944-46 1 ☐Yes 2 X No Specify: <u></u> Specify: 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Carpenter Union 1849 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Robinson Ira Nichols 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau Latanya Jimerson/Daughter 6192 Pronghorn Ct. Waldorf, Maryland 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State City View Cemetery 11/25/08 Pasco, Washington 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Adams Funeral Home PA 21. Signature of June Service Licenses 20605 Aquasco Rd. Aquasco, Maryland 20608 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of) Examiner SPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit TRACT RINARY Due to (or as a consequence of) Box 68760, Physician/Medical STEDMITE IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier MD 65329 NOVEMBER 14 2008 me and address of person who completed cause of death (Item 23a) (Type, Print) DBX SOUTHERNS MARCHAND HOSPITAL CLINTON MD 20739 ABASSI MD KASHEGO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Please Type or	Print in	Black	Indelible Ink.	Ensure All	Copies	Are Legible
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			Registrar 1. Decedent's Name (First, Middle, Las	et)		Cer	unca	le OI L		Т	2. Date of De	Reg. I	Vo.	ng.	3. Time of De	
П	Physici /Medic		Joseph Thomas R	*							Month Octobe	[Day 2	Year 2008	2:20 A	
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	Funeral Director			X 2 □ F	72	Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D Aug. 6	<i>ay, Y</i> ea	9. Birthplace (State Country) 1936 Maryl		Marylar	nd
	pu 🛊		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							1	0d. Inside City	Limite
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	or 28a	by Funeral Director	10e. Street and Number	-			10f. Z	ip Code				10g. Citizen of What Country?				
	s 23a	eral	1011 Annapolis Re		=:-116	140.1	21054						U.S			
(0	fter de ritem	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Yes 2 ☐ If Yes, Give	,	1	f Yes, sp	ecify Cubar	n, Mexican	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)	D-		ck, White,		
21215-0036	ours a	d by	3 ☐ Widowed ♣️♣️Divorced	If Yes, Give Year or Dates:	1959-	-61	1 □ Yes	2 X No	Specify:				Specify	/: Wh	nite	
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pu	tal Hy d othe	Be	17. Father's Name (First, Middle, Last)								(First, Middle		en Surnam	ne)		
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Baltimore,	es 1 au of Hea i item rothe		20a. Method of Disposition		20b. Pl	lace of Dispo: emetery, cren	sition (Na	ame of other place			ate		Location -		wn, State	
ij	Page tment tant: It jury o		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		_	Ltimore	e Cre	emato	cy 1		/2008				aryland	ì
Bal	permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Waden Ever. Inc. 1906.		21. Signature of Funeral Service Licer	isee Vi	11),			and Address				_			l Home MD 214	101
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-	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	()	oke										Onset and Dea	ath
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):									2 (404)	
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0. B	e deat the att	Physician/Me	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Other (Мо	onth	Day Yea	ar
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<u>~</u>	hysician: The law his certificate has b I director, page 2 sl	Completed									auto perfo 1 □ Yes	rmed?	, (death? 1 ∐ Yes		se oi
Vita	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death	(Check only	one)				
of	Phys rthis ral dir	٠ <u>:</u>	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Inju		ER/Outpatien 28b. Time of		Other 28c. Injury	TLI NUI		ne 5 Res				y)	
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	10.	6		0.0				D6 40	89			10	1221	2008		
	多	"ע	30. Name and address of person who Mark Sanchiz	completed cause of c	death (Item	23a) (Type, I	Print)			Ome !	101:5	MI)			
	Sta	te	31. Date filed (Month, Day, Year)	08 32 Registr	rar's Signat	ye d	este	,	7 '		nolit	, N	J			
	Registr	ar	OCT 2 4 20	UU JUNEAU		1										

Certificate of Death

2. Date of Death

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3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☑ No

Michigan

White

4:35 A M

Division of Vital Records, P.O. Box 68760,

1 - For State Registra

1. Decedent's Name (First, Middle, Last)

use as the burial-transit attending physicien 2 Completed To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. Be

disease or condition resulting in death)	a. Concer L	LVETHICK		1 year
resolding in death)	Due to (or as a consequence of):			1
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that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ctopic pregnancy ther (specify)		23d. Date of delivery Month Day Year
Part ff. Other significant conditions of ementions		orlying cause given in Part I.	23e. Did tobacco i	use contribute to the cause of death?
diabetes	mellitu		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical		26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 E No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othor	ome 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Statural 5 Pending 2 Accident investigation		28c. Injury at Work? M 1 Yes 2 No	28d. Describe how intui	ry occurred
3 Suicide 6 Could not be 4 Homicide determined		, factory, office	28f. Location (Street ar City or Town, State	od Number or Rural Route Number, a)
29a. Certifier (Check only one) 1 Certifying Pl	hysician: To the best of my knowledge, death or miner: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and place stigation, in my opinion, death occu	, and due to the cause(s rred at the time, date and	and manner as stated. d place, and due to the cause(s)
29b. Signature and title of certifier	0 1 1 1	29c. License number	29d. Da	te signed (Month, Day, Year)
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State Registrar ss of person who completed cause of death (Item 23a) (Type, Print)

32. Degistrar's Signature

Melnick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1840 PM Elizabeth Renner ovember 25 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1 □ M 2 🕅 F Yrs. 215-18-2611 **Director** 85 Nov. 25, 1923 Maryland Usual Residence of Decedent Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shortha Medical Examiner must be notified at MDWashington 1 ☐ Yes 2 X No Director Hagerstown death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12037 Belvedere Road 21742 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify. Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Baker ဥ Earl R. Paden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gregory A. Wilkes/Son-In-Law 6134 W. Denney's Road, Dover, DE 19901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 12/6/2008 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complif a ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** insocial e Inche (ale Aut /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ Schentre 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unikinown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate nope 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural 5 Pending s after death.

I Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and MO D18819 NOV 26, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HACERSTOWN MOZIOND VASANT DATTA 340 MILL ST no 31. Date filed (Month, Day, Year) 32 Registrar's Signature-State Registrar

08-08504

Amend 19b, per FH G886 12/15/08 TT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Mandand / Department of Health and Mental Hygiene

		- For State Certificate of L Registrar 1. Decedent's Name (First, Middle,Last)	Death I	Reg. No.	08 3875
hysicia Examir		Shelton D. Stephens		Month Day Year November 12, 2008	1944 hrs
		4a. Facility Name (if not institution, give street and number) 4b	City, Town, or Location of Death	4c. County of Dea	ath
		ooco orani ingiliray	Waldorf	Charles	Pieth place (Ctata a
neral ector	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 247-08-1165 1 XM 2 F 52 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min.	Fore	eign South Country) Carolin
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n		10d. Inside City Limits
≥		Florida Marion Dunnello	n		1 Yes 2 X No
23a or 28a-f sho	Director	the state of the s	10f. Zip Code	10g. Citizen of What Co	ountry?
or 28	Ë	11228 North Riverbend Road	34432	U.S.A.	
s 23a e noti			Decedent of Hispanic Origin? (Sp	pecify Yes or No- 14. Race - Am	erican Indian, Black,
r item	Funeral	1 Never Married 2 X Married Armed Forces? If Yes 1 Yes 2 X No	s, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	
ner m	by F	Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:	Specify: Wh	
xami		during mos	s Usual Occupation (Give kind of vectors) stood working life. DO NOT use reti		ss/Industry
tealth and Mental Hygiene. tem 27 is marked other than "natur traumatic event, the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	/Operator	Boat Tr	ailer
Hygiene.	- E	17. Father's Name (First, Middle, Last)	_	e (First, Middle, Maiden Surname)	arrer
al Hygi ed oth it, the	-			stevens	
Mental marked c event,	0	John Benjamin Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	-		ate, Zip Code)
h and 27 is		Marvin Stephens 2638St	tephens Road,	Rural Route Number, City or Town, St. Bethune Beyhune, South Date 20c. Location - City	Carolina29
		20a. Method of Disposition 20b. Place of Disposition crematory or other	ion (Name of cemetery,	Date 20c. Location - City	or Town, State
nt of P		1 XBurial 2 Cremation 3 Removal from State Harmony 4 Donation 5 Other Specify: Church Ce	Baptist 11-	-20-08 Bethune,	South Caro
oartme oortai iry or	~ 10	4 0	emetery ame and Address of Facility Ma	rzullo Funeral	Chapel, P.
Depart Impor injury	()s	Mulhael P. Margullo 600 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	09Harford Roa	d.Baltimore,Ma	ryland2121
sician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as cardiac	or respiratory arrest, shock, or heart	
edical miner	11	Immediate Cause (Final disease a. Cutting Wound of Neck	V 01	18	Death
IIIIIei		or condition resulting in death) Due to (or as a consequence of):			
	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		*11	
	Ë	Cisease or injury that initiated			
sit	Examiner	events resulting in death) Last Due to (or as a consequence of):			
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ysician burial	Medical	UNPENDED X AMENDED Item#20b.perFH.G	886.12/4/08.WS	23d. Date of deli	Nerv.
the attending phy hed for use as the l	N/M	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fett	al death 3 Ectopic pregn		Day Year
tendin use a	sician/M	past 12 months? 4 Pregnant at time of death 5 Oth	ner (Specify)		
the at ed for	Phys	1 Yes 2 No 9 Unknown g Unknown		23e. Did tobacco use contribute	to the source of death?
ned by the	by P	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	1 Yes 2 No 3	
is been signed be should be deta					e autopsy findings available
has bee	Completed			autopsy prior death	to completion of cause of
2 2	шо			1 Yes 2 No 1 V	
ate h	l O	25. Was case referred to medical	26.Place of Death (Check		
ertificate h	a)	examiner? Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other Nurs	ing Home 5 Residence 6 ✔ O	ther: Scene
this certificate h	o Be	T V Yes 2 No			
After this certificate h uneral director, page 2	To Be	27. Manner of Death 28a. Date of Injury 28b. Time of In 28d. Mggth P8xXear) 1940 brs		28d. Describe how injury occurred Subject cut	
After this certifi	To Be	27. Manner of Death 1 Natural 5 Pending Nov 12, 2008 1940 hrs 28a. Date of Injury (Month. Day Year) 1940 hrs	1 Yes 2 ✔ No	Subject cut	Durch Device Number City
After this certifi	To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be Could	1 Yes 2 ✔ No	Subject cut 28f. Location (Street and Number o	
After this certifi	o Be	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Parking Lot 28a. Date of Injury Nov 12, 2008 1940 hrs 28b. Time of In 1940 hrs 28b. Place of Injury - At home, farm, stree (Specify) Parking Lot	1 Yes 2 ✓ No 1, factory, office building, etc.	28f. Location (Street and Number o or Town, State) 3550 Crain Highway, Waldorf, M	MD
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hin 24 hours after death. the Funeral Director: After this certifi npletely filled in by the funeral director,	Certification: To Be	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physician: To the basis of examination and/or investigation and manner stated. 28a. Date of Injury (Month. Day Year) 1940 hrs 28b. Time of Investigation 1940 hrs 28c. Place of Injury - At home, farm, stree (Specify) Parking Lot	1 Yes 2 ✓ No if, factory, office building, etc. red at the time, date and place, an	28f. Location (Street and Number o or Town, State) 3550 Crain Highway, Waldorf, M	MD stated. to the cause(s)
After this certificate funeral director, page	To Be	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) Parking Lot 28a. Date of Injury Nov'12, 2008 1940 hrs 28b. Time of In 1940 hrs 28b. Time of In 1940 hrs 28c. Place of Injury - At home, farm, stree (Specify) Parking Lot 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	1 Yes 2 ✓ No It, factory, office building, etc. red at the time, date and place, and ion, in my opinion, death occurred 29c. License number	28f. Location (Street and Number of or Town, State) 3550 Crain Highway, Waldorf, Mand due to the cause(s) and manner as that the time, date and place, and due to the cause (a) Date signed	stated. to the cause(s) (Month, Day, Year)
After this certifi funeral director,	Certification: To Be	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) Parking Lot 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr (Check only one) 29b. Signature and title of gertifier	1 Yes 2 ✓ No If, factory, office building, etc. Yes 2 ✓ No Yet, factory, office building, etc. Yet at the time, date and place, are ion, in my opinion, death occurred	Subject cut 28f. Location (Street and Number of or Town, State) 3550 Crain Highway, Waldorf, Mod due to the cause(s) and manner as at the time, date and place, and due to	stated. to the cause(s) (Month, Day, Year)
After this certifi funeral director,	Certification: To Be	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) Parking Lot 29a. Certifier (Check-only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)	1 Yes 2 ✓ No It, factory, office building, etc. red at the time, date and place, and ion, in my opinion, death occurred 29c. License number	Subject cut 28f. Location (Street and Number of or Town, State) 3550 Crain Highway, Waldorf, Mod due to the cause(s) and manner as at at the time, date and place, and due to the signed November 13	stated. to the cause(s) (Month, Day, Year)

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. SMED of Mary and beharmer From Seatth and Mental Shygiene AMEND ITEM#6perFHeenincate 2/15/08 WS Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Nov. 2008^a 8:05 P Anna Virginia Sisler /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 18798 E. Wilson Rd SE Allegany Oldtown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. M 2K F 213-40-3869 May 21, Director 89 1919 Oldtown, MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ms 23a or 28a-f show must be notified at MD Allegany Oldtown 1 ☐ Yes 2X☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21555 18798 E. Wilson Rd U.S.A. items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 6 1 ☐ Yes 🎇 ☐ No Specify Specify: White Completed by 3€ Widowed 4 Divorced "naturaj" Department of Health and Mental Hygiene Important: if Item 27 is marked other than "nature any injury or other traumatic event, the Medical once." 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon S. Dolan Goldie M. (Robertson) Dolan ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Slider 15707 Oldtown Rd SE, Oldtown, MD 21555 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Davis Memorial Nov. 29, 08 Cumberland, MD 22. Name and Address of Facility Hafer Funeral Service, P.A. 21. Signature of Funeral Service Licensee 1302 National Hwy., LaVale, MD 23a. Party Enter the disease, or complifations t shock, or heart failure. List only one cause that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest to one of the chain. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Day EDOBROUM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last g physician ar the burial-t Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Par II. Other significant con in ions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page ORO DAR 2 **X**No 1⊟ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Funerai E To the Hospitai within 24 hours a To the Funeral C 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ER 27 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 904 Seton Dr., Cumberland, MD 21502 Robert Welik MD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 17 Rev 1/2001

DEC 0 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Alayne Swimpson 15,2008 10:30^{a м} November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death xaminer Prince George Crescent Cities Center Riverdale If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day. **Funeral** Months Days Hours Min. 02,1965 1 ☐ M 2 🗙 F 43 224-13-8373 Virgina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edigal Examiner must be notified at Md Mitchellville Prince George 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20721 USA 1608 Post Oak Drive Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23sury or other traumatic event, the <u>Medigal Examiner must</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PHD College (1-4or 5+) Elementary/Secondary (0-12) DC Public Schools School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Clarence Swimpson Sr Rosa Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\sharp\,517$ Rosa Wilkerson(Mother) 077 Largo Road, Upper Marlboro Maryland20774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If Its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem 11/21/08 Clinton Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Icensee Tyrone J. Young719 Kennedy St. NW Wash, DC 23a. Part1. Ener the dis shock, or heart failu Immediate Cuse (Final r the disease, or complica heart failure. List only one Do not enter the mode of dying, such as cardiac or respiratory arrest, OVARY Merastases with **Physician** 4 PAR ATGWOMA disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. by Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day 5 Other (specify) signed by the a Ö 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2**X** No 1 Yes 2 No Division or Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To : After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury (Month, Day Year) To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

10

State Registrar

31. Date filed (Month, Day, Year) NOV 2 1 2008

29b. Signature and title of certifier

DuamsBury Rd Hyattonille MD 20781 32. Registrar's Signature

4203 (

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WE VORE MA

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#10c.PerFHPGC11-21-08crCertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1017 AM STEADMAN THEOLORE 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TAKOMA PARK MD MONTGOMERY ADJENTIST HOSP WASHINGTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (Start or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 № M 2 □ F Months Days Hours Min 3 518 28 46 43 8 Washington, DC Director 02/24 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7. Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 x Yes 2 No Director Prince Georges MD 44ATTS VILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20782 4922 LASALLE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Forces? 1 ☑ Yes 2 ☐ No Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: BLACK 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) 9th College (1-4or 5+) Government Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Abe Steadman Ida May Drumming ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 Is
any injury or other trau
once. Ruth Harrell/ Step- Daughter 5507 Bosworth Ave., Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico National Cem. 11/21/2008 Triangle, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Sign Jury of Funeral Service Licenses Johnson & Jenkins Funeral Home ta OU Kusen 716 Kennedy St. NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on usefulne. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumou /Medical Dil- to (tras a consequence of) Examiner Opers Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a masequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 1 🗌 Yes 2 🔲 No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

the

State Registrar

31. Date filed (Month, Day, Year) 1 2008 NOV 2

29b. Signature and title of certifier

30. Name and address of person who

32. Registrar's Signat

and manner stated.

and pleted gause of death (Item 23a) (Type, Print) 29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Dolores Ann Spach 8:23 P 2008 November 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital Center Clinton 8. Date of Birth (Month, Day, May 29, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex ^{Year)} 1928 Min. Days 1 □ M 2√XF Hours Maryland 216-22-0506 80 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 1 ☐ Yes 2 🔏 No Maryland Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20772 USA 14616 Crescent Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □ Yes 2XXNo White Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Edward Ridgely Marie Michel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ross E. Spach, Sr./Husband 14616 Crescent Dr., Upper Marlboro, MD 20772 Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place)

11-17-08

Edgewater, MD

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

is 23a or 28a-f show

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Director

Funeral

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Completed

Be

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1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jaime F. Botello, M.D.

31. Date filed (Mo

4 ☐ Donation 5 ☐ Other (Specify)

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	21. Signature of Fugeral Strice Licensee	,	1	Solomons Isla	_			
	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not be cause on each line. Due to (or as a consequence of	Arte	` `	or respiratory arrest,		Approximate Interval Between Onset and Death	
ucai Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to for as a consequence of Due to (or as a consequence of						
ysicianyme	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							
an by ri	Pary Other significant conditions cont	ributing to death but not resulting in たいららげ	the underlying	cause given in Part I.	23e. Did tobacci		o the cause of death? robably 4 Unknown	
naidillos	Rengl Fall	ure			24a. Was an autopsy performed? 1 □ Yes 2 □ 1	death?	utopsy findings available completion of cause of s 2 \sumbox No	
0 00	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Ho	ospital: 1 Inpatient 2 ER/Out	tpatient 3 ☐ D	Othor	th (Check only one) ome 5 Residence	6 □ Other (Spe	ecify)	
allon:	27. Manner of Death 1		Time of njury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in			
Serunc	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factor	ry, office	28f. Location (Street City or Town, Sta	and Number or Fate)	tural Route Number,	
alical	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examin	lcian: To the best of my knowledge er: On the basis of examination and and manner stated.	, death occurred d/or investigation	d at the time, date and place on, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner a and place, and du	as stated. e to the cause(s)	
IVIE	29b. Signature and title of certifier		29	9c. License number D 19889	29d. [Date signed (Mon	th, Day, Year)	

Kalas Crematory

DHMH 17 Rev 1/2001

State Registrar 1328 Southern Ave, S.E. Washington, D.C. 20032

Amended Items 29a & 30 per N.P. 11/17/2008 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov^{Month}15 Day 2008 Year **Physician** Rowena Jean Seiler 3:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1723 Sams Creek Road Westminster Carrol1 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | May 23 Birthplace (State or Foreign Country)
 Ohio 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 S F 84 219-18-7798 1924 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Director Carrol1 Westminster 1 ☐ Yes 2 ₹ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1723 Sams Creek Road 21157 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2x No Specify ð 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "nat any injury or other traumatic event, the Mexicologe. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid Springfield State Hosp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie Ear1 Morgan Matilda **Florance** Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seiler 1729 Sams Creek Road, Westminster, MD Don son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition IEBurial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park Nov 19 2008 | Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burrier-Queen Funeral Home Toll 14 1212 W. Old Liberty Road, Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEATA Denile dementa disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 P.0. Records, Division of Vital 28a-f show

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23a

or items

"natural"

72 hours after

Maryland 21215-0036

Baltimore,

traumatic event, the Medical Examiner must be notified at

Physician /Medical **Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed hed by the attending physician and detached for use as the burial-tran signed I icate has been si , page 2 should b certificate this certific al director, Certification: To After thin 24 hours after death.

the Funeral Director: A suppletely filled in by the fu death. 29a. Certifier Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Nurse Practationerstated. 2 Medical Examiner:

X Nurse Pract To the I within 2.
To the I complet 29b. Signature and title of certifie icense numberغالم 29c 29d. Date signed (Month, Day, Year) 11.17.08 115117 MJI MP umou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simone H. Brady, C.R.N.P. SUITE 114 01157 Wmc drive 51 minstor 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State NOV 1 7 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			Please Type or Print in Bia State of Maryland 1 - State Registrar	/ Depa		and Mental Hygi	_	3 3 3 7 6 0
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Doris Euler Saffron			2. Date of Death Month NOVEMBE	Day Year R 14, 20	3. Time of Death
3	Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cen	iter	4b. City, Town, or Location	n of Death Towson	4c. County of Dea	n ltimore
	Funeral Director		5. Social Security Number 215-09-9954 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8. Date of Birth (Month, Day, June 13	Year) 9. Bir Co 1919 Mar	thplace (State or Foreign buntry) 'y Land
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation			10d. Inside City Limits
	e Mary 3a-f sh	ctor	Maryland Carroll S	ykesv	ille			1 □ Yes 2 ² ⊡ Wo
	3a or 28	al Director	10e. Street and Number 4837 Bushey Road		10f. Zip Code 21784		g. Citizen of What Co J nited St a	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, it is firedical Exactive Luuri be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of Hispanic (f Yes, specify Cuban, Mexic ☐Yes 2 No Speci	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - Ame Black, Whit Wh Specify:	
21215-0036	within 72 hou jiene. r than "natura the Medical E	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	lent's Usual Occupation kind of work done during m OO NOT use retired) Cretary	ost of working	6b. Kind of Business. altimore (of Educa	County Board
Maryland 2	uld be filed Mental Hyg irked othe itic event,	To Be C	17. Father's Name (First, Middle, Last) John Wesley Euler		18. Mot	ther's Name (First, Middle, Ma Edith May Clu	,	
, Mary	and 2 shousalth and Programs 27 is maser trauma		19a. Informant's Name/Relationship (Type. Print) Suzanne Linville - Daughter	19b. Mailin 4837	g Address (Street and Num Bushey Road	Sykesville,	City or Town, State, MD 21784	Zip Code)
Baltimore,	Pages 1 and the surt of He surt: If item			· View	sition (Name of natory or other place) Mem. Park	Nov. 17, 200		le, MD
Balti	permit. P. Departme Importan any Injury		21. Signature of Funeral Service Lice see	22 B 1	Name and Address of Facurrier-Queen 212 W. Old L	Funeral Home iberty Road W	& Cremato infield, N	ory, PA D 21784
-	Physician		23a Part 1. Enter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. ACUTE MYO resulting in death)		er the mode of dying, such		st,	Approximate Interval Between Onset and Death
- American	/Medical Examiner		requiring in death) Due to (or as a conseque) CARDIOGEN	nce of):				
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		1 Stort book 1 S			
,092	te be executed ysician and e burial-transit	sal Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequent of the consequent	nce of):				
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O. Box	that the death certificate ned by the attending physi detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea	leath 3 □	Ectopic pregnancy Other (specify)	 	23d. Date of de Month	livery Day Year
rds, P.	quires that n signed b	by	Part II. Other significant conditions contributing to death but not resulti	ing in the ur	nderlying cause given in Par	1 ☐ Yes	1/	o the cause of death?
of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed					prior to death? No 1 Yes	utopsy findings available completion of cause of
Vita	sician s certif lirector	o Be	25. Was case referred to medical examiner? 1 \[Yes 2 \] No Hospital: 1 \[Inpatient 2 \] Inpatient 2 \[Elimeter El	R/Outpatier		ace of Death (Check only one Nursing Home 5 🗆 Resider		
on of	tding Phys th. : After this funeral dii	ition: To		8b. Time of Injury	28c. Injury at Work? M 1 Yes 2	28d. Describe how		eury)
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office	28f. Location (Stri City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowl and manner stated.					
		Me	29b. Signature and title of certifier.		29c. License numbe		d. Date signed (Mon	th, Day, Year)
	MIZ		30. Name and address of person who completed cause of death (Item 2	23a) (Type.	D46356	· //	ovember	14,2008
_			MIGCOOL TODOCCI M D 70	D14 D1	THE PROPERTY.	TOWSON, MAR	RYLAND 2	1204
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 1 7 2008	re <i>A</i> c	1	· —		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11 14 2008 3 P. John David Summers 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Glade Valley Nursing Home Walkersville Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/20/1926 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days **™** M 2 □ 214-28-7259 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ∐Yes ≩∏No MD Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21704 USA 5955 Ouinn Orchard Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 ☐ Never Married XXMarried 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) farmer agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Seymour F. Summers Annie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5955 Quinn Orchard Rd., Frederick, MD21704 Winifred Summers (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Buriş Cremation 3 temoval from State Lutheran Cemetery 11/18/2008Middletown, MD 5 Other (Specify 21. Sign Donald B. Thompson Funeral Home 18, Middletown, MD caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cayse (Final disease or cordition tic Coronary VOSCU Sugars

Physician /Medical Examiner

Physician

/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner manet be a superior once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	re-minoring eatin)	Due to (or as a consequence of):	7		J
iner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events	b			
ical Exan	that initiated events resulting in death) Last	Due to (or as a consequence of):			
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oic pregnancy r (specify)		te of delivery onth Day Year
ed by Ph	Part II. Other significant conditions co	ontributing to death but not resulting in the underlyi	ing cause given in Part I.	23e. Did tobacco use con 1 ☐ Yes 2 X No	tribute to the cause of death? 3 □ Probably 4 □Unknown
Somplete				autopsy performed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	Othor	tth (Check only one) ome 5 ☐ Residence 6 ☐ Oth	ner (Specify)
ation: T	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	red
ertifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,
Medical Certification:		vsician: To the best of my knowledge, death occurring: On the basis of examination and/or investig and manner stated.			
Me	29b. Signature and title of certifier	CRUP	29c. License number		ed (Month, Day, Year)
		completed cause of death (Item 23a) (Type, Print)	.21702 K	athryp Track	pecrup

DHMH 17 Rev 1/2001

State

Registrar

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2008

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 4:00 PM Gedmnesh Seifu 11/20/2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🕱 F Days Min. Months Hours 628-52-7498 80 7/23/1928 Ethopia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1342 Foxglove Square 21017 Ethopia 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify 3 X Widowed 4 ☐ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Seifu Woldyohannes Worekenshe Guluma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bizuwork Negash/Daughter 1307 North Barrett Lane, Newark, Delaware 19702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 12/01/2008 Ethopia Ledata Cemetery 21. Signature of Ameral Service Licensee 22. Name and Address of Facility Funeral Choices of Chantilly M00968 14522L Lee Road, Chantilly, VA 20151 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) ancreation 6 months Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔀 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

r than "natural", or items 23a or 28a-f sl

nd Mental Hygie marked other t

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Department of Heal Important: If item 2 any injury or other once.

other

Baltimore, Maryland 21215-0036

30/08 1600 pm

Funeral Director

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Completed

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Examine physician and the burial-transit Physician/Medical After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as t \$ Completed certificate Be Certification: To Director:

eftu, GedamneshM&DD50069 Division of Vital Records, P.O. Box 68760,

9 Unknown

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

5 Pending investigation 1 Natural 2 Accident 6 Could not be 3 ☐ Suicide determined 4 Homicide

29a, Certifie

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

138125

29d. Date signed (Month. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

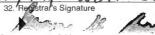
State Registrar

completely filled in by

within 24 hours a

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31. Date filed (Month



Hopkins Community Physicians Riverside 1321 Riverside Parking, Suite A Belcamp, MD

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aac) III CI		lept 10/29/08 dlvState of Maryland / Department of F - State Registrar Certificate of I	teaith and ivi Death			38763
			1. Decedent's Name (First, Middle, Last)		2. Date of Deat		3. Time of Death
	Physicia	in	Gail Ruth Skaradek		Month October	20, 2008	8:30 PM
1	/Medic Examin			r Location of Death		4c. County of Deat	h
			Magnolia Gardens Lanham	T If I Index Od His T	O. Dtf Di-ti	Prince Ge	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2X F 87 Yrs. 1 □ M 2X F 87 Yrs.	Hours Min	8. Date of Birth (Month, Day Aug. 31	(, Year) Co	hplace (State or Foreign untry) ntucky
	Director	-	404-14-8223 8/ Pris. Usual Residence of Decedent		Aug. Ji	, 1721 Ke	
	ryland how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 X Yes 2 ☐ No
	ne Ma 8a-fs	ecto	Maryland Prince George's Lanham			10g. Citizen of What Co	
	with the	Funeral Director	10e. Street and Number 10f. Zip Code 2070	16		USA	unity
	ns 23	era	6028 Nava1 Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe	cify Yes or No-		
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2-("natu	lete	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired	oation during most of workir	ng	16b. Kind of Business/	Industry
12	within ene. than	dmc	Elementary/Secondary (0-12) 12 College (1-4or 5+) Cashier	4		Giant Food	
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Medical Examiner must be recilied at any injury or other traumatic event, if a Medical Examiner must be recilied at ance.		19a. Informant's Name/Relationship (Type. Print) Michael Skaradek/ Son 19b Mailing Address (Streat Norfolk)	Road G	Route Number	Lismb 210	Zip C ^{ode)}
e,	1 and Healtl em 27		Michael Skaradek/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		ate TID	20c. Location - City or	
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量	artme ortan injur					Evans Funer	
ä	Der any		Eca Anna 16000 Anna	apolis Roa	d Bowie	, MD 20715	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line.	ng, such as cardiac o	or respiratory an	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition Cerebro Vascular Disease—S	Stroke			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate b. Alzheimers Disease Due to (or as a consequence of):				
	executed in and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
oʻ	e exec an an irial-tr		resulting in death) Lest Due to (or as a consequence of):				
376	ate be hysici the bu	lical	W _{d.} Hypertension				
P.O. Box 68760,	aath certificate be executed attending physician and for use as the burial-transit	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	livery
8	atten for us	cian	in the past 12 months?	су		Month	Day Year
0	the di yy the ached	ysi	1 Yes 2 The grant at time of death S Other (specify) 9 Unknown				
·	s that med b	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ğ	en sig	edk			1 🗆 Y	′es 2\$€No 3∐P	robably 4 Unknown
မိုင	law re las be 2 shd	Completed			24a. Was a	an 24b. Were a prior to	utopsy findings available completion of cause of
Ξ π	cate h	Con			1 🗆 Yes	rmed? death? 2 No 1 □ Yes	2 No
Vita	lcian certifi ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
o	Phys r this eral di	1: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury	4 ES Nursing Ho		dence 6 Other (Spe	ecify)
o	ndlng th. :: Afte e fune	ation	1 [XNatural 5 □ Pending (Month, Ďay, Year) Injury Wor 2 □ Accident investigation M 1 □	rk?]Yes 2 □No			
Division of Vital Records,	r Atter ter des irector	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	:	28f. Location (ร City or To ผ	Street and Number or R	ural Route Number,
	pital o		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the t	time date and place	and due to the	cause(s) and manner a	s stated
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the built	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurr	red at the time,	date and place, and du	e to the cause(s)
	To the To the Comp	Me	Lob. Orginator o and the control	se number		29d. Date signed (Mon	
	. V.	Q		034/20		10-22-	-08
	K B	/	38. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Vicker Poochikian 5632 Annapolis Road, Blade	enchura M	m 20710)	
	Sta	ate	31 Date filed (Month, Day, Year) OCT 2 4 2008 32 Registrar's Signature	choburg, n	20/10		
	Regist	rar	OC 2 4 ZUUS James St. Spelle				

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	_1	For State Registrar	State of Ma	ryiand /		rtificate of E		Re	g. No. 2 () ()	3 33764	
Physicia	n	1. Decedent's Name (First, Middle, La MARJORIE ALI		מי				2. Date of Death Month NOVEMBER	Day Year		
/Medica		MARJORIE ALI 4a. Facility Name (If not institution, given				4b. City, Town, or I	Location of Death	MOAFMEE	4c. County of De		
Examine		Casey House-6001	· · · · · · · · · · · · · · · · · · ·	4ill R	oad	Rockv:			Montgo		
Funeral Director		5. Social Security Number 6. S 216-30-4895		(In yrs. last I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 6	Year) 1911 Ma	irthplace (State or Foreign Country) aryland	
a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Md. Montgo:	mery	10c. City, To		cation hersburg				10d. Inside City Limits 1 XYes 2 □ No	
23a or 28	ral Director	10e. Street and Number 9 Chestnut Stree	t #309			10f. Zip Code	20877	10	g. Citizen of What C United S	-	
0,5	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Ye} \) N If Yes, Give Year or Dates:		1	Was Decedent of His If Yes, specify Cubar 1 □Yes 2 No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: V		
ene. than "natu re Medicel	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1.2	ducation a <i>d</i> e co <i>mpleted)</i> College (1-4or 5+ 1		(Give life. l	dent's Usual Occupa kind of work done du DO NOT use retired) emaker	tion uring most of worki	ing 1	6b. Kind of Busines Own Hor	,	
Mental Hygi irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last	son, Jr.		22011		18. Mother's Name	(First, Middle, M	aiden Surname)		
ealth and h		19a. Informant's Name/Relationship Ann S. Ferguson	(Type. Print) / Daughte:	2 :	19 W	ng Address <i>(Street</i> a alker Avei	nue, Gait	hersburg	, Md. 20	0877	
ment of He ant: If iten jury or oth		20a. Method of Disposition 1				sition (Name of matory or other place e Cemeter		20/08	Oc. Location - City of Germant	or Town, State	
Depart Import any in		21. Signature of Funeral Service Licensee Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882									
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer Due to (or as a consequence of):								or respiratory arre	st,	Approximate Interval Between Onset and Death	
physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a								
ohysicia the bur	edical		d								
he attendin ed for use	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal dea		☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of d Month	lelivery Day Year	
en signed b ould be deta	ed by Phy	Part II. Other significant conditions Congestive H			g in the u	nderlying cause give	n in Part I.		acco use contribute s 2 □ No 3 □	to the cause of death? Probably 4 Unknown	
cate has be	Completed							24a. Was an autopsy perform 1 □Yes 2	prior to	autopsy findings available o completion of cause of ? es 2 □ No	
sertific ector,	Be	25. Was case referred to medical examiner?	Hospital			Otho	26. Place of Deatl				
this all dir	유	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		Outpatier		r: 4 Nursing Ho	me 5 Reside		pecify) Hospice	
death. stor: After the funer	Certification:	1 ♠ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	(Month, Day	Year)	Injury	M 1 □ Y	? ′es 2 □No			Rural Route Number,	
urs after eral Direc illed in by		4 Homicide determined	building, etc	(Specify)			an data and place	City or Town	State)		
hin 24 ho the Fune	Medical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination ted.	and/or in	nvestigation, in my op	pinion, death occur	red at the time, da	ite and place, and d	ue to the cause(s)	
Sor With	4	29b. Signature and title of certifier Decelyne k					637u 2	1	nd. Date signed (Mo. November		
01		30. Name and address of person who Jocelyne Kouatch	ou, M.D.	6001	Munc	aster Mil	1 Road, I	Rockville	e, Md. 20	0855	
Stat Registra		31. Date filed (Month, Day, Year) NOV 1 8	2008 Registra	r's Signature		Sparle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended#26perMD, FCHD, SG Certificate of Death !!/18/08 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** $A^{\,\mathsf{M}}$ 14 2008 9:23 November Sechler Franki Renee /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Mt. Airy Kline Hospice House 9. Birthplace (State or Foreign Country)

Maryland 8. Date of Birth (Month, Day, Year) June 12, 1971 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2**X**□ F Months Days Hours 37 216-70-0215 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "indical Experiment out by northed at 1 ☐Yes 2 XNo Directo Maryland | Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21702 USA 8314 Edgewood Church Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Franklin William Norris Carol A. Brandenburg ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 8314 Edgewood Church Road, Frederick, Maryland 21702 Kenneth Sechler - husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

Locust Valley Bible Date 20c. Location - City or Town, State 20a. Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 11-18-2008 Middletown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CY Stauffer Funeral Home 201621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Glioblastoma Physician 40 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Exami g physician and is the burial-trans Due to (or as a consequence of): Physician/Medical as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 🗹 No 1 □ Yes 2 🗆 No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 And American Grant Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this within 24 hours a completely

filed within 72 hours after death

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

attending for use as signed by the a nours after death. neral Director: Af filled in by the fur

6 Could not be determined

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

4 1866 November 14,2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

468 Thomas Johann Drive, Snite 200 Frederick, MO 21702 Kanan Hudhud, MD

31. Date filed (Month, Day, Year!

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

Medical

State Registra 32. Registrar's Signature

mo

		1 - State Registrar		,	Cer	tificate of l	Death		Reg. No.	. UUS	301	00
		1. Decedent's Name (First, Middle	. ,					2. Date of D		Year	3. Time of Dea	ath
Physicia /Medic		Martha	Frances S	hafer				Novem			10:00 A	M A
Examin		4a. Facility Name (If not institution				4b. City, Town, or	r Location of De	eath	4c. Co	ounty of Death	1	
		Northampton Ma				Freder				Frede		
Funeral		5. Social Security Number 217–80–2943	6. Sex 7. Ag	je (In yrs. last b 87	yrs.	If Under 1 Year Months Days	Hours M	in. (Month, I			place (State or Fo intry)	reign
Director		Usual Residence of Decedent	A	07	110.			June	29, 19	21 Man	ryland	
land ow		10a. State 10b. County		10c. City, Tox	wn or Loc	ation					10d. Inside City Li	imits
Mary -fsh	ğ	Maryland Fre	ederick	Kno	oxvi	lle					1 □Yes 2🛚] No
r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Cou	intry?	
h with	밀	4019 Burkit	tsville Rd.			217.	58		Unite	d Stat	es	
deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. W	Vas Decedent of H Yes, specify Cuba	lispanic Origin?	(Specify Yes or N	lo- 14.	Race - Amer		
after or it	F	1 Never Married 2 Marr	ried 1 Yes 2 X	No	- 1	□Yes 2√√No	Specify:	orto riioari, cto.,		Black, White becify:	White	
ural",	d b	3 XWidowed 4 ☐ Divorced	Year or Dates:									
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Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home												
filed Hygi other	ပ္	17. Father's Name (First, Middle,	Last)	1			18. Mother's N	lame (First, Midd	e, Maiden Su	rname)		
d be ental ked c	To Be	James	W. Gei	sler			Marth	a S.	Brander	nburg		
shoul nd M mar	-	19a. Informant's Name/Relations	hip (Type. Print)	19	b. Mailing	g Address (Street	and Number or	Rural Route Num	ber, City or To	own, State, Z	ip Code)	
nd 2 aith a 27 is		Patricia Lanca	aster / daug	hter	4115	Burkitts	sville 1	Rd./ Kno	xville	MD	21758	
s 1 a of Hea item othe		20a. Method of Disposition		20b. Place	of Dispos	ition (Name of atory or other place	100	Date	20c. Locat	ion - City or T	own, State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evaring must be notified at once.		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				s Cemete	i	21/2008	Pet	ersvil	le, Mary	land
mit. partn porta y inju		21. Signature of Funeral Service	Licensee	100. 1.		Name and Addres			ffer F			
9 3 E 8 9		1 on may	Strack	ler		1621 Op	ossumto	wn Pike,	Frede	rick,	MD 21702	
		23a. Patt 1. Enfer the disease, pr shock, or heart failure. List	complications that cause only one cause on each li	d the death. Do ne.	o not ente	er the mode of dyin	ng, such as card	liac or respiratory	arrest,		Approximate Interval Between	n
Physician		Immediate Cause (Final disease or condition	P	Imo			nholu				Onset and Deat	h
/Medical		resulting in death)	Due to (or as	a consequence	e of):	1		/				
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eath certificate be executed attending physician and for use as the burial-transit.	Medical											
anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy					23d	l. Date of deliv	/ery	
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at the by th tache	Physician	9 Unknown	9 ☐ Unknown								·-	
es tha	by	Part II. Other significant condition	ons contributing to death b	ut not resulting	in the un	derlying cause give	en in Part I.	23e. Did	tobacco use		the cause of death	
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law r nas be 2 sh	ed	Atri	cel Fihri	lotin	n			24a. Wa	san 2 opsy	4b. Were aut	opsy findings avail	lable e of
The page	Completed							per	formed? 2 No	death? 1 □ Yes		
sician: The law requires that the di certificate has been signed by the rector, page 2 should be detached	Be	25. Was case referred to medical examiner?						eath (Check only	one)			
Physical this cal dire	၉	1 ☐ Yes 2 No	Hospital:				4 20 Nursing	Home 5 ☐ Re			ify)	
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death death ctor: y the	ical	2 ☐ Accident investion 3 ☐ Suicide 6 ☐ Could in	not be	urv - At home	farm stre		Yes 2 □No	28f Location	(Street and N	lumbar or Pu	al Route Number,	
lor A after Direction by	ertii	4 Homicide determ	ined 28e. Place of Infi building, et	c. (Specify)	idiii, siio	or, ractory, ornoc		City or To	wn, State)	amber or nar	ai rioute Number,	
spita nours neral		29a. Certifier 1 Certifylr	ng Physician: To the best	of my knowled	ge, death	occurred at the tir	ne, date and pla	ace, and due to th	e cause(s) ar	d manner as	stated.	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2☐ Medical one)	Examiner: On the basis of and manner st		and/or inv	estigation, in my o	pinion, death o	ocurred at the time	e, date and pla	ace, and due	to the cause(s)	
vithii To th	Ž	29b. Signature and title of certifie				29c. License			29d. Date s	igned (Month	Day, Year)	
(101)		Cuest	in Dorra			009	689		11/	11/08		
141		30. Name and address of person	who completed cause of o	leath (Item 23a					<u>-</u>			
(), '		Austin Pear			St./	Frederic	ck MD	21701				
Sta Registra		31. Date filed (Month, Day, Year)	0 0000	ar's Signature		1						
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 26 2008 11:38 A M EUGENE STUP /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Dec. 11, 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Days Hours Min 1 □ M 2 □ F 215-26-1419 86 1921 Director Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 🎗 ☐ No Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 5822 Butterfly Lane 21703 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give^Δ Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after of ealth and Mental Hygiene. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Completed by Specify: White 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumatic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event, the Magnetic event e Elementary/Secondary (0-12) College (1-4or 5+) Owned and Operator Equipment Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Archie Franklin Stup Ruth Ellen Clav ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joyce D. Stup, wife 5822 Butterfly Lane, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery Nov. 29, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached f P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? certificate | 2 100 1 ☐ Yes 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3 No ≥ ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Matural 5 Pending investigation ours after death. neral Director: A filled in by the fu death 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 West 9th Street, Frederick, MD 21701

29d. Date signed (Month, Day, Year)

29c. License number

D 16428

Casper Cline, M.D.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

DEC 04 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Joseph John Slusarski, Sr. ovember de 2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 8. Date of Birth (Month, Day, Yea Time 30, ge (In yrs. last birthday) If Under 1 9. Birthplace). 1922 15 M 2□ F Wisconsin 86 398-24-4774 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XX es 2 No Harford MD Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 328 Mt. Royal Avenue 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: & Korea 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Civil Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leo Slusarski Agnes Glowienki 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Bechtol (Daughter) 3100 Buttersea Lane, Alexandria, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co. 11/24/08 West Chester, PA 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (oronany Disease Due to (or as a consequence of) Sequentially list conditions, if any leading characteristic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of: Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2√2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 A vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🗖 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

Examiner burial-transit ンパンな/ った/ しょうり こうくらん Division or Vital Records, P.O. Box 68760, attending physician as nse igned by the cale has been si , p. ge 2 should b certificale has

Physician/Medical Completed funeral director. Be Certification: or Attendated after death

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3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

Physician

/Medical

Examiner

Funeral

Director

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"natural", or items 23a

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and Mental Hygiene.

Department of Health a Important: If item 27 is any injury or other tra

Physician /Medical

Pages 1 and 2 should be

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filed within 72 hours after death with Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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filled in by To the Hospital of within 24 hours at To the Funeral D 124

29b. Signature and title of certifier

2008

determined

29c. License number D32609

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

t**€** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1106 Levelution St Harre De Green Malo 78 Mussayors Kammidus

31. Date filed (Month, Day, Year) State Registrar DEC 0 3

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month GEORGE EDWIN SPOONER, SR. November 23 2008 Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEDICA Plata HARLES Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | A UG 9 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months WASHINGTON 1 X M 2 □ F 035-16-8606 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. CHARLES WALDORF 1 ☐Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2862 LYON COURT 20602 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?

1 □▼es 2□No NAVY
If Yes, Give RET • CHE F 1□Yes 2☒No Specify: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U.S.NAVY (RET) Elementary/Secondary (0-12) College (1-4or 5+) COMMUNICATIONS SPECIALIST J.S.GOVT. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDWIN GEORGE SPOONER LILLIAN LOCKFORD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE IRESON-DAUGHTER 2862 LYON CT. WALDORF, MD. 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD. VETERANS CEM. 12-2-08 CHELTENHAM, MD. M00479 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Se prentially that and the if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 🗌 Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined

Physician /Medical Examiner

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evancinar must be notified at

death with the Maryland

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attending physician been signed by the should be detached has After this

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

death. after death Director:

within 24 hours a

Examiner Physician/Medical Be

þ Completed

Certification: To filled in by

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State Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of beg

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cenna Medical **Ubhas** 31. Date filed (Month, Day, Year)

4 Homicide

29a. Certifier (Check only one)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** McKinley Thompson John 18, 2008 6:30 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Casey Hospice House If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 □ F 230-18-4051 83 August 5, 1925 Virginia Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Experient must be notified at Director District of Columbia Washington 1 XYes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with 20019 1103 - 50th Place, NE United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any or other traumatic events. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 XYes 2 No Black, White, etc. 1 Xes 2 If Yes, Give Year or Dates: African 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify 3 3 □ Widowed 4 □ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Government Postal Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Thompson Burlett Jackson ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise B. Turner - Daughter 1103 - 50th Place, NE Washington, DC 20019 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet's Cemetery Nov 25, 2008 Cheltenham, MD 4 Donation 5 □ Other (Specify) 21. Signature of Funer II Service 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final , Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Clusease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as 1 IF FEMALE asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. been signed by the should be detached 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy certificate 1 □Yes 2X□No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospice Other: 4 Nursing Home 5 Residence 6 MOther (Specify) House Hospital: 1 ∐ Yes 2 🖾 No To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1¥ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kouatchou, mi 200 63 74 8 November 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyn Kouatchou, M.D. 6001 Muncaster Mill Road Rockville, MD 20855 32. Registrar's Sign NOV 2 1 2008 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $^{\text{Day}}$ 15, $\frac{\text{Year}}{2008}$ Month **Physician** Richard Howard Tracey November 1:15 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 56 218-54-3931 23, Director March 1952 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 TYes 2 No Director MD Carroll Taneytown 10e Street and Number 10f. Zin Code 10g, Citizen of What Country? a or 21787 3319 Old Taneytown Road USA ns 23a must b Funeral "natural", or Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 homent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natul.
Iny or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homebuilder Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary L. Sharrer Myron R. Tracey ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne C. Tracey, wife 3319 Old Taneytown Rd., Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. St. Joseph's Cem. 11/18/2008 Taneytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home Quotin R M01191 worken 136 E Baltimore St., Taneytown, MD 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRYTHMIA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any least the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Profit Property THYROIDISM 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No certificate 1∐ Yes Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending (Month, Day Year) 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0054580 17, 2008 M.D. II 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

INASIM FAKHAR M.D. 417 E BALT SE # D, TANEYTOWN MD 21787 8

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

Colines

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 8:45 A 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOSEPH JOHN TISZL 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility.Name (If not institution, give street and number) 4c. County of Death Examiner PR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Days Min 1 M 2 □ F Months Hours 2/16/1920 Mary land 88 214-16-2491 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland reent of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or hitems 23a or 28a-f show ury or other traumatic event, Pre Madical Examiner must be notified at ury or other traumatic event, Pre Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No PA York Fawn Grove **Funeral Director** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 17321 **USA** 294 Mill Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Was Deceden Armed Forces?

Yes 2 No WWII Specify: White 1 ☐ Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Cable Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Wagoner Joseph John Tiszl ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 294 Mill Street, Fawn Grove, PA 17321 Anna J. Tiszl/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Nourial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 12/1/08 Pylesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signatur of Funeral Service Licens 22. Name and Address of Facility 17314 Harkins Funeral Home, Inc., Delta, PA art 1. Into the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only pre cause on each line. mmediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Iriju y that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed anding physician and use as the burial-tran-Due to (or as a consequence of) P.O. Box 68760, attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 5 Other (specify) cate has been signed by the a page 2 should be detached it ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐Yes 2 No 1 ☐Yes 2 ☐No or Attending Physician; the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospitai 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0015044

State Registrar JANNE L. C 31. Date filed (Month, Day, Year)

DEC 0 4

DHMH 17 Rev 1/2001

36 Wedslane Fawn Grove, Ra

30. Name and address of terson who completed cause of death (Item 23a) (Type, Print)

MD

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	,	C	Certificate of L	Death		Reg. No.	000	30//3
			1. Decedent's Name (First, Middle, La.	st)				2. Date of De Month	ath Day	Ye ar_	3. Time of Death
	Physicia /Medic		James Milton Voor	chees, Jr.				Novemb	er 13	2008	10:05 A M
	Examin		4a. Facility Name (If not institution, giv				Location of Death			unty of Death	
, gr			3921 River Club I			Edgewate				e Arund	
	Funeral Director		5. Social Security Number 6. S 084-20-6637	Sex 7. Age (<i>In yr</i> s. i	last birtho Yr	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 08/31/	1927	9. Birthp Court New Y	lace (State or Foreign try) ork
	pu »		Usual Residence of Decedent 10a. State 10b. County	I 10c Cit	V Town o	r Location				1	0d. Inside City Limits
	short	5			,						1 □Yes 2 No
	28a-1	Director	Maryland Anne Art	inger rage	ewate	10f. Zip Code			10g. Citizer	n of What Coun	trv?
	with Ba or	ä	3921 River Club I	Drive		21037				d State	1
	ms 2;	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S.	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp			Race - Americ	an Indian,
•	or ite	Ē	1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 XYes 2 □ No		1 ☐ Yes, specify Cuba	n, mexican, Puerto Specify:	rican, etc.)		Black, White,	
	ral", c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1945-	-46	Till fes 2MN0			Sp	^{pecify:} Whi	te
	filed within 72 hours after death with the Maryland Hygene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner ment be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. D	ecedent's Usual Occupa Give kind of work done of ife. DO NOT use retired	ation furing most of work	ng		of Business/Ind	*
į	within sne.	d L	Elementary/Secondary (0-12)	College (1-4or 5+)]	Lf-employed)		Tools	ruction	1
1	Hygie Hygie ther i		17. Father's Name (First, Middle, Last,)	per	ir emproyed	18. Mother's Name	(First, Middle,		rname)	
3	d be a	o Be	James Milton Voor				Mina Wan				
	shoul nd Me mark	ဥ	19a. Informant's Name/Relationship (19b. N	Mailing Address (Street a	and Number or Run	al Route Numb	er, City or To	own, State, Ziç	Code)
	nd 2 salth a		Elaine G. Voorhe		392	21 River Cl	ub Drive,	Edgewa	iter,	Marylan	d 21037
Ś	s 1 au of Heg item othe	1.8	20a. Method of Disposition	20b. P	Place of D	risposition (Name of crematory or other place	e) [Date	20c. Locat	tion - City or To	wn, State
2	Page hent c int: If		1 ⚠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			Memorial Gard		7/2008	Davids	sonvill	e, Maryland
Dalimino	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ange.		21. Signature of Funeral Service Local			22. Name and Addres					
בֿ	B a E a	1	m/1/6		1	2973 Solom	ons Islan	d Road,	Edge	water,M	ID 21037
			23a Part 1. Enter the disease, or com-	plications that caused the death one cause on each line.	h. Do not	t enter the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· (ONGE	ST	IVE HEA	et F	Allur	13	17	Onset and Death WO YEARS
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of)						
	Exammer	Ļ	Sequentially list conditions,	b	-01						
	ted nsit	Examiner	Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	nence ou						
	execu and al-tra	xar	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of)	:					
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Š	ifficat g phy as the	Medical									
5	eath certificate be executed attending physician and for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		3 ☐ Ectopic pregnancy	,		230	d. Date of delive	
,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of c		5 ☐ Other (specify) _	, 			Month	Day Year
	d by t	Phy	9 Unknown Part II. Other significant conditions	contributing to doubt but not son	ulting in th	ho underlying eause give	on in Part I	23e Did t	tohaceo use	contribute to ti	ne cause of death?
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ב ב	has ye 2 s	효	11LOSTATE	CANCER				24a. Was autop	psy prmed?	prior to co death?	psy findings available mpletion of cause of
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5	g Phy er this eral d	ĭ	27. Manner of Death	28a. Date of Injury	28b. Tin	ne of 28c. Injur	TI INGISHING THE	28d. Describe			<i>y</i> /
5	nding ath. r: Afte e fun	i i i	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year) n	Inju		(? Yes 2 □ No				
DINISIOII OI	Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm	n, street, factory, office		28f. Location (Street and N	lumber or Rura	I Route Number,
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	To the Hospital or Attending Physician: The law requires that the de within 24 hours affer death. To the Funeral Director: Affer this certificate has been signed by the acompletely filled in by the funeral director, page 2 should be detached.	Medical		hysician: To the best of my kno miner: On the basis of examina and manner stated.							
	o the ithin i	Mec	29b. Signature and title of certifier	and manifer stated.		29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)
•	⊢≶Fŏ			Du		HS) 5	5224	5	Novs	MBER	14 2008
•		1	30. Name and address of person who	completed cause of death (Iter	n 23a) (Tv	ype, Print)					,,
1	H)(H		MICHAEL F	REEDMAN	116	0 - 1	- Hishu	iony 1	Anna	DULIS	14, 2008 , MO 2140
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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year November 14, 2008 1045 Walker, Jr. Ernest Lee 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Bethesda Suburban Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Months Davs Hours 1**X** M 2□ F 78 June 22, 1930 Pennsylvania 207-20-4311 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County N☐Yes 2 ☐ No District of Columbia Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20019 4629 Minnesota Avenue, NE 12. Was Decedent Ever in U.S. Armed Forces? 1 Tytes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 years College (1-4or 5+) Private (Safeway) Meat Cutter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mabel Hammonds Ernest Lee Walker, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4629 Minnesota Ave., NE Washington, DC 20019 Paulette Grady - Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov 24, 2008 Washington, DC Glenwood Cemetery 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Si nature of Funeral Service Live 4001 Benning Road, NE Washington, DC 20019 23a. Part . Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. Immediate Lause (Final disease or condition resulting in death) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ARRHYDIMIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ENCEPHALOPATH DYSPHAGIA 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 21XN0 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important; If Item 27 is any Injury or other trau once.

Physician

/Medical

Examiner

Director

Completed by Funeral

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ed other than "natural", or items 23a or 28a-f show event, the Medical Examinan must be mutified at

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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law requires that the death certificate be executed 68760, Box Ö ø. Records, Vital or Attending Physician: o Division To the Hospital within 24 hours To the Funeral

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	al Director: After this certificate has been signed by the attending physicia	led in by the funeral director, page 2 should be detached for use as the buri	Certification: To Be Completed by Physician/Medical
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IF FEMALE:

29a. Certifier

(Check only one)

25. Was case referred to medical examiner? 1∐Yes 2No 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 ☐ Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

CHABLANE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

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State

Registrar

			For State Registrar	State of Maryland		artment of rtificate o			-	giene Reg. No.	2008	33776
			Decedent's Name (First, Middle, Last	t)					. Date of De			3. Time of Death
	Physici		Marvin James	Washington,	Tax			N	Month	Day	Year	
-	/Medic Examin		4a. Facility Name (If not institution, give		JI.	4b. City, Town	or Location		ovembe		<u>, 2008</u> County of Dea	
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	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or items 23a or 28a-f show ent, the Medical Experience reast be notified at		10a. State 10b. County		Town or Lo							10d. Inside City Limits
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9	or ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ▼Yes 2 No		If Yes, specify Cu			can, etc.)	}	Black, Whit	e, etc.
21215-0036	urs a	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2⊠XN	o Specify:	•			Specify: B	lack
9	2. ho	Completed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occ	upation			16b. Kin	d of Business	/Industry
218	hin 7	읦	(Specify only highest gra			kind of work don DO NOT use reti						
21;	giene giene	ĕ	Ziomoniary (o 12)	2 years (1-4or 5+)	Ind	ustrial	Engine	eer		Go	vernme	nt
	othe /ent,	Be	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (F	First, Middle,	Maiden S	lurname)	
Maryland	ild be fenta rked ric ev	10	Marvin D. Washir	gton			Et	thel J	ames			
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₫	artme ortan		Donation 5 ☐ Other (Specify 21. Signature of Funeral Service pices	Was	hingt	on Nat 1 2. Name and Add	Cemt.	Nov	25, 20	800	<u>Suitla</u>	nd, MD
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Ä	he law te has age 2 s	Ē							autop perfo	rmed?	death?	completion of cause of
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month Day 4:50 \mathbf{P} M JACQUELINE ODESSA WILKERSON NOV -2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8201 ARUNDEL DRIVE FORT WASHINGTON PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) FEB. 18, 1927 9. Birthplace (State or Foreign 6. Sex 1 □ M 2 F Months Days Hours 81 PENNSYLVANIA 577-32-0679 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10h County 1X Yes 2 No PRINCE GEORGE'S FORT WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20744 8201 ARUNDEL DRIVE USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 -0-HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HORACE V. OURS NELLIE SCHRIEVER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MALCOLM F. WILKERSON, SR./HUSBAND 8201 ARUNDEL DRIVE, FORT WASHINGTON, MD 20744

Department of Health Important: If item 27 any Injury or other troopies.

Physician

/Medical

10a. State

MD

Examiner

Funeral

Director

28a-f shov

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23a

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Health and Mental Hygivem 27 is marked other

Directo

Funeral

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Completed

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29b. Signature and title of certifie

STEVEN SEIGEL, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pages 1 and 2 should be filed within 72 hours after death with the Marylan

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 68760,

	20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	amount from State	Place of Disposition (Na cemetery, crematory or STERFIELD (me of other place) EMETERY NOV.		Location - City or T	,
	21. Signature of Funeral Service License	efenbein	FELLOW 408 S	nd Address of Facility S, HELFENBEIN LIBERTY ST	& NEWNAM]	FUNERAL HOLLE, MD 2	OME, P.A. 1617
	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.					Approximate Interval Between Onset and Death
	disease or condition resulting in death)	Due to (or as a conseq		LMUNAKI DISI	LASE	-	5 YRS
miner	Sequentially list conditions, if any, leading to firm solutions cause. Enter Underlying Cause (Disease or injury that initiated events	Justo (or as a coneaq	uence off:				
cal Exa	resulting in death) Last	Due to (or as a conseq	uence of):				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	I death 3 Ectopic			23d. Date of deli	very Day Year
d by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacc		the cause of death?
Complete					24a. Was an autopsy performed 1 ∐Yes 2 ∑	prior to c death?	opsy findings availab ompletion of cause of 2 □No
Be	25. Was case referred to medical examiner?			· 1	eath (Check only one)		
မ	ILITES ZINO		ER/Outpatient 3 C		Home 5 Residence		ify)
ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred	
ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factor	y, office	28f. Location (Street City or Town, St	and Number or Rul ate)	ral Route Number,
Medical Certification: To		sician: To the best of my knowner: On the basis of examination and manner stated.					
Me	29h Signature and title of certifier		20	Ic License number	204	Date signed /Month	Day Year)

DHMH 17 Rev 1/2001

State Registrar 29c. License number

6104 OLD BRANCH AVENUE, TEMPLE HILLS, MARYLAND 20748

D0066377

29d. Date signed (Month, Day, Year)

NOVEMBER 17, 2008

Division or Vital Records, P.O. Box 68760

=	onarics werre								
	19a. Informant's Name/Relationship (Virginia D. We		Mailing Address (Street and Number or Run 9100 Townsend Lane,	ral Route Number, City or Town, State, Clinton, MD 207					
	20a. Method of Disposition	20b. Place of D	Disposition (Name of	Date 20c. Location - City or	Town, State				
	1 ☐ Bunal 2 ∭ACremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specif</i>	Inemoval from State	crematory or other place) rematory Nov 18, 20	08 Clinton, M	D				
	21. Signature of Funeral Service Licer	nsee	22. Name and Address of Facility Lee	Funeral Home Inc	6633 014				
	Jouis T. Frank	L mooasy	Alexandria Ferry I		20735				
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death				
	disease or condition	_a Alzheimer's I							
	resulting in death)	Due to (or as a consequence of):							
	Commentally that are different	b							
<u>u</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of)):						
	cause. Enter Underlying Cause (Disease or injury that initiated events								
Y	resulting in death) Last	Due to (or as a consequence of)):						
0									
3		_d							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown									
	Part II. Other significant conditions of	contributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?				
ממ				1 □ Yes 2XXNo 3 □ P	robably 4 □Unknown				
1				24a. Was an 24b. Were a	utopsy findings available				
É				autopsy prior to performed? death?	completion of cause of				
3	05 144			1 Yes XX No 1 Yes	No No				
6	25. Was case referred to medical examiner?	Hospital:	Othor	th (Check only one)					
2	1 ☐ Yes XXNo	1 Inpatient 2 ER/Outp		ome XX Residence 6 □Other (Spe	ecify)				
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Tin (Month, Day Year) Inju		28d. Describe how injury occurred					
3	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At nome, farm	n, street, factory, office	28f. Location (Street and Number or R	ural Route Number,				
4 ☐ Homicide determined building, etc. (Specify)									
ulcal	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
1	29b. Signature and title of certifier	`	29c. License number	29d. Date signed (Mon	th, Day, Year)				
	Destrut	7 - 00	1466665	Nov 14, 20	08				
	30 Name and address of person who	completed cause of death (Item 23a) (Ty	ype, Print)		1				
_]	UR. Dona Lesk	MSK1 9200 Bas	11 court # 200 K	2190 MM 207	74				
•	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1						
r	NOV 1 8	2008 Alexan St.	KIDOME!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits 1 ☐ Yes 2 No

1:00A M

Day

2008

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

Construction

United States

14. Race - American Indian

White

Black, White, etc.

Prince George's

Maryland

State

Registrar

N35

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 13. Year **Physician** 2008 Pearl L. Wyatt 21:41 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
1921 Florida 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Hours Min. Year) Months Days 1 □ M 2 🙀 F March 12, 87 261 16 4282 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Express must be notified at aprile. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 □Yes 2 □No Director Maryland Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20735 United States 9402 Paul Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: Vietnam Specify. Specify: Black þ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Army Retired 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Henrietta McMillan Henry Rowe ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9402 Paul Drive, Clinton, MD Sean Wyatt (Son) 20b. Place of Disposition (Name of Nov 25, , Dag 2008 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD Maryland Veterans Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of ce 053209 erson who completed cause of death (Item 23a) (Type, Print) urratts Rd Clinton Md 20735 7503° maall 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 11 | Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:30^{P™} Richard Woodard October 17, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 3850 Enfield Chase Court #205 Bowie If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 9. Birthplace (State or Foreign Country) New Jersey Sex 1XXM 2□F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 83 June 24, 1925 **Director** 243-24-2212 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shormust be notified at 1 XYes 2 No Funeral Director Prince George's Maryland Bowie 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number USA 3850 Enfield Chase Court #205 20716 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 14. Bace - American Indian. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any Injury or other traumatic event, The Medical Event and once present once. Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: '44-'46 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐Yes 2 XNo Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) New York City Elementary/Secondary (0-12) College (1-4or 5+) Police Officer/ Detective Police Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lydia Nixon ဥ Isaiah Woodard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perquita Woodard/ Wife 3850 Enfield Chase Court #205 Bowie, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland
Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/24/2008 | Cheltenham, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NON-Small 5 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 □Yes 2 DNo 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1 Yes 2 No 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Mapner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Division** 1 Natural
2 Accident 5 Pending investigation filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the within 2 29d. Date signed (Month, Day, Year) canine weem, MD DS2830 October 20, 2008

1/2 State

State Registrar

31. Date filed (Month, Day, Year)

900 BSrggte Road # 300, AMEPSIS, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 2 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible: State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No._ 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Kenneth Paul West October | 21 2008 1:00 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 1**X** M 2 □ F 216–68–8720 54 Yrs. July 12, 1954 Maryland

10f. Zip Code

1 □Yes 2\times\text{No

Entrepreneur

(Give kind of work done during most of working life, DO NOT use retired)

16a, Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Crematory

Annapolis

21409

Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 □ No

Year

10g. Citizen of What Country?

14. Race - American Indian,

White

Black, White, etc.

U.S.A.

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

22. Name and Address of Facility John M. Taylor Funeral Home

Eleanor Murray

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1827 Hidden Point Road Annapolis, Maryland

16b. Kind of Business/Industry

Self Employed

20c. Location - City or Town, State

10/23/2008 Baltimore, Maryland

1 ☐ Yes 2√2No

10c. City, Town or Location

Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r than "natural", or items 23a or 28a-f shov If a Medical Examirar must be notified at 28a-f show Baltimore, Maryland 21215-0036 7 is marked other traumatic event, 1 permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.

Physician

/Medical

Examiner

Usual Residence of Decedent

10b. County

1827 Hidden Point Road

15. Decedent's Education (Specify only highest grade completed)

1X Never Married 2 ☐ Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Harold R. West, Jr.

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service La

19a. Informant's Name/Relationship (Type. Print)

Harold R. West, Jr./father

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Anne Arundel

12. Was Decedent Ever in U.S. Armed Forces?

1 ∐Yes 2**X** No If Yes, Give Year or Dates:

College (1-4or 5+)

10a State

Director

Completed by Funeral

Be

ပ္

Maryland

11. Marital Status

10e. Street and Number

Funeral

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760, attending pl for use as t s been signed by the a should be detached i nis certificate has director, page 2 s this funeral After ours after death.

neral Director: A
filled in by the fu death. To the Hospital within 24 hours a To the Funeral L Hospital

147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) 8 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2. No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 5 10 23 30. Name and addess of per on who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, OCT 2 4 2008 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 815 PM WIECHELT AKEN NOVEMBER 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** None 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Hours 194-56-3265 44 Director 03-17-1964 Texas Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Director 1 ☐ Yes 21 No MD Howard Columbia 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 7239 Steamerbell Row 21045 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Never Married 2 🔀 Married ō 1 ☐ Yes 2 XNo Specify: \$ 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry the Medica (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Elementary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be th and Mental F 27 Is marked ot traumatic ever and 2 should be John Mierzwa Marcia McOuiston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Kevin F. Wiechelt/Husband 7239 Steamerbell Row Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important; If iter any Injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 11-18-2008 Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Collins-0 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications to t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between PERE BRAL Onset and Death Immediate Cause (Final HERNIATION **Physician** disease or condition resulting in death) DAY /Medical Due to (or as a consequence of) Examiner SCHEMIC INFARCT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) HEMORRHAGE burial-transit UBARACHNOID death certificate be executed Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No page 2 should be detached 9 N Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? the funeral director. 26. Place of Death (Check only one) Be Hospital: 1 AInpatient 1 ☐ Yes 2 XNo 2 \square ER/Outpatient 3 □ DOA 4
Nursing Home 5 Residence ၉ 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after death. Certification: I or Attending I after death. 1 Natural 5 Pending investigation Injury 1 Tes 2 🗌 No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours 29a. Certifier 1 *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES -000 NOVEMBER 16,2003 ne and address deperson who completed cause of death (Item 23a) (Type, Print) (P) 2 Johns Homeins 600 North Wolfe St, Baltimore, MD, 21287 RAZA MEYER 8-161 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 9 2008 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

P.O.

of Vital Records,

Division

Registrar

DHMH 17 Rev 1/2001

e of Maryland / Department of Health and N Certificate of Death	Mental Hygiene	0.5
Certificate of Death	Reg. No. 2008	38
DVC VIDCINIA MOI EE	Date of Death Month Day Year	3. Time of

Physic /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Regist

	For State Registrar	Ce	rtificate of			g. No. 2008	38785		
an	1. Decedent's Name (First, Middle, Last)	VIDCINIA	MOLEE		Date of Death Month	Day Year	3. Time of Death		
al		VIRGINIA		r Location of Death		r 17, 2008 4c. County of Death			
er	4a. Facility Name (If not institution, give street and number CARROLL HOSPICE DOVE		MINSTER		CARROLL				
	5. Social Security Number 6. Sex 7. A	9. Birth	nplace (State or Foreign						
	201-24-4320 Usual Residence of Decedent	76 Yrs.	Months Days	Hours Min.	(Month, Day, March 23	, 1932 Vir	ginia		
	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits		
tor	Maryland Frederick	Mount A	iry				1 X Yes 2 □ No		
Funeral Director	10e. Street and Number	•	10f. Zip Code		10	g. Citizen of What Co	untry?		
la L	301 Prospect Road 21771 U.S.A.								
nue	11. Marital Status 12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White			
y F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 If Yes, Give 3 ☐ Widowed 4 🛣 Divorced Year or Dates		o 1 □ Yes 2 X No Specify:			Specify:			
Completed by	15. Decedent's Education	16a. Dece	edent's Usual Occu	ation	. 1	6b. Kind of Business/l	ite ndustry		
plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give life.	e kind of work done DO NOT use retire	during most of wor d)	king				
Com	12		inistrati			U.S. Gover	nment		
Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, M.	,			
2	Harvey Kimberlin	10b Moili	ing Address (Street	Ethel		Leonard City or Town, State, Z	Tin Codo)		
	19a. Informant's Name/Relationship (Type. Print)								
	David J. Wolfe - Son 20a. Method of Disposition	20b. Place of Disp	Prospect osition (Name of	i	Date 2	y Marylan Oc. Location - City or	Town, State		
	1 ☐ Burial 2 【图Cremation 3 ☐ Removal from Stat 4 ☐ Depation 5 ☐ Other (Specify)	e l	ematory or other pla itan Cren	· ;	11/19/08	م المسلم و معرود 4 م	. Virginia		
	21. Signature of Funeral Service Licensee	2	Name and Address	ss of Facility			_		
	Fourt L. Hillian	D	amascus.	Maryland	20872	uneral Hom	ie		
	23a. Part1. Enter the disease, or complications that caus- shock, or heart failure. List only one cause on each	ed the death. Do not en line.	nter the mode of dyi	ng, such as cardiad	or respiratory arres	st,	Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease or condition routing in doub)	ASIH,	<i>(</i>)				Oriset and Death		
	resulting in death) Due to (or a	s a consequence of):							
<u></u>	Sequentially list conditions, if any leading to immediate b. Due to (or a	s a consequence of):							
min	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events								
Exa	resulting in death) Last Due to (or a	s a consequence of):							
edical Examiner	d								
	IF FEMALE:								
23b. Was decedent pregnant 23c. If yes, outcome pregnancy 23d. Date of deliver							very Day Year		
ysic	1 Yes		Otrier (specify) _						
y Ph	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause gi	ren in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
d b	DEMENTIA 1 Yes 2 No 3 Probably 4								
olete	24a. Was an autopsy fir autopsy prior to completi								
autopsy prior to comple death? 1 Yes 2 No 1 Yes 2									
Be (25. Was case referred to medical examiner?	ath (Check only one							
²	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Spi								
ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, L	Day Year) 285. Time of Injury				at 28d. Describe how injury occurred ? 'es 2 □ No			
icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of i	eet and Number or Ru	ıral Boute Number						
ertif	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number or Rural Ro								
Medical Certification:	(Check only 2 Medical Examiner: On the basis	of examination and/or i		h occurred at the time, date and place, and due to the cause(s) and manner as stated. Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)					
Med	one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
	Cours SHAMPS (MOCHAN		poole	WESTM	mi Mish	np 2/15)		
ite	31. Date filed (Month, Day, Year) 32. Region	strar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1010 PM (5 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day) **Funeral** 1 M 2 F Months Days Hours Min NONE Yrs. Director June 132008 Jaryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercitive metinals at Director 1 ☐ Yes 2 ☑ No Maryland Howard Ellicott 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 4705 Shelley Lone Funeral 21043 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Newborn Newborn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental I Malker aroline Halker David 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 i Lane Ellicott City Maryland 21043 aroline Walker mother Department of Health Important: If item 27 any Injury or other the once. 4705Shelley 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State October 5 2008 Baltimore Mary land New Cathedral Cemetry 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 21229 AGNES HOSPITAL Ken ad 200 BALTIMORE, MD AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Extreme Prematurit /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) I∐Yes 2-No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 24 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

DannaGold

DEC 04

31. Date filed (Month, Day, Year)

3

MD

egistrar's Signatere

900

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

D006020

aton Avenue Baltimore Maryland

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylan		artment of F <i>rtificate of I</i>			giene Reg. No.	3 3 3 7 8 7
	Dhysisi	8	Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	ath Day Yea	3. Time of Death
. N.	Physicia /Medic			Ernest Wolfe	2	4h Oin Tour		Nov.	22, 2008	4:25 P ^M
?	Examin	er					4c. County of De			
	Funeral		,	6ex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	v, Year)	irthplace (State or Foreign Country)
ŀ.	Director		322-16-2087 Usual Residence of Decedent	92	Yrs.			July 13	3,1916 I	PA
	yland now at		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	ne Mar Ba-f sl	ctor	MD Baltim	ore	Fr	eeland				1 Yes X No
	a or 2	Dire	10e. Street and Number 1515 Freeland	Poad		10f. Zip Code 210	53		10g. Citizen of What (Country?
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	.S. 13.		ispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-		nerican Indian,
ဖွ	after or ite	/ Fur	1 Never Married 2 Married	1 X Voc 2 1 No		1 ☐ Yes 2 № No	Specify:	Hican, etc.)	Black, Wh	
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2	filed within Hygiene. ther than " ent, the Mer	Com	12		Pos	tmaster			U.S. Gove	ernment
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ary	should and Men marke	우	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street			er, City or Town, State	
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Joyce E. Biedron						ter, MD 2	
altimore,	Page: net o int: If i		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the conte	Removal from State 20b. M t fy) M∈	Place of Dispo Cemeter, Fre Cthodi	osition (Name of matory Grotles place of Ceme	Nov.		20c. Location - City of Freeland	
Balti	permit. Departn Importa any Inju		21. Signature of Funeral Service Lice		2	2. Name and Addre	ss of Facility J.J	. Harte	enstein Mo eedom, Pi	
Ē			23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the deal	th. Do not en	ter the mode of dyir	g, such as cardinc o	or respiratory ar	rrest,	Approximate Interval Between
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~			IF FEMALE:							
Box	leath certific attending p I for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	aldeath 3[□Ectopic pregnancy □ Other (specify)	′		23d. Date of o Month	lelivery Day Year
Ö.	t the d	hysi	1 Yes 2 No 9 Unknown	9□ Unknown						
Records, P	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	by	Part II Other significant conditions	contributing to death but not res	0	inderlying cause giv		23e. Did to	~/	to the cause of death? Probably 4 □Unknown
000	ie law require has been sig ge 2 should b	Completed		7				24a. Was autop		autopsy findings available o completion of cause of
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o	Attending Physician: r death. ector: After this certifics by the funeral director, I	n: To	27. Manner of Death	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	nt 3 DOA	4 L Nursing Ho		dence 6 Other (Sp now injury occurred	pecify)
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Division or		Certification:	3 ☐ Suicide 6 ☐ Could not be determined.					28f. Location (S City or Tow	(Street and Number or Rural Route Number, own, State)	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowner: On the basis of examinating and manner stated.	owledge, dea ation and/or in	th occurred at the tin envestigation, in my o	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and d	as stated. tue to the cause(s)
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			Breunt	DD.		1100	25384	3	11/24/20	208
	10+1		1/	completed cause of death (Iter	m 23a) (Type,	Print)	ings I	TRIVE	110	21-78-7
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	'i	1100		1000	(1)
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aird vvallace		State of Maryland I-For State Registrar	•	ent of Health an eite of Death	d Mental Hy		a. No. 2 (1	08 3278
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Laird William	1	Wallace		2. Date of Death	Day Year	3. Time of Death 1358 hrs
	4a. Facility Name (if not institution, give street and number) 112 Decatur Street, Apt #1				Location of Death		4c. County of De	eath .
Funeral Director	щ,	5. Social Security Number 6. Sex 7. A	ge (In yrs. last birth	day) If Under 1 Yea Months Day	r If Under 24Hrs:		(MM/DD/YYYY) 9:	Birthplace (State or Foreign Country)
		215-76-9962 1X M 2 F Usual Residence of Decedent	42	Yrs.		02/24/	1966 N	Malawi
d how any		10a. State 10b. County MD Allegany	10c. City, Town o	Cumberland				10d. Inside City Limits 1 X Yes 2 No
e Maryian or 28a-f si	Director	10e. Street and Number 112 Decatur Street, Ap	+ #1	10f. Zip Code	502	10	g. Citizen of What C	-
1822(Funeral D	11. Marital Status 1 X Never Married 2 Married Armed Force	nt Ever in U.S.	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe			nerican Indian, Black,
bours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	by Fur	3 Widowed 4 Divorced If Yes, Give Year or Dates:	2 X No	1 Yes 2 X No	specify:		Specify:	White
36 n 72 hours nan "natu ical Exan	15. Decedent's Education Elementary/Secondary	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) College (1-4 of 12)	d	Decedent's Usual Occupa uring most of working life Laborer			16b. Kind of Busine	
		17. Father's Name (First, Middle, Last)			18.Mother's Name		aiden Surname)	caping
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, MD and 2 shor eafth and en 27 is rraumati	1	Elizabeth J. Wallace / Mot		1501 Summit			1 buquerqu	ie, NM 87112
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Balt permit Departu Import injury	V	1. Fignature of Funeral Service Licensee		22. Name and Address				1 Home, P.A. 21502
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caminer		Immediate Cause (Final disease or condition resulting in death) a. Methador Due to (or as a cor		cation		1, +		
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ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed eath. In the certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - trans	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)						23d. Date of deli Month	Day Year
.O. Bc		Part II. Other significant conditions contributing to de	ath but not resulting	in the underlying cause of	given in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
ls, P.O. quires that then signed by all doe detact	ted by					1 Yes	-	Probably 4 V Unknown a autopsy findings available
of Vital Records, ig Physician: The law require ther this certificate has been is moral director, page 2 should be	Completed	·				autops perform	y prior ned? death	to completion of cause of
Vital Rehysician: The this certificate	o Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpa	ient 2 ER/Ou	26.Place	Other: Nursing		Residence 6 🗸 O	ther: Scene
ion of \text{tending Phy} eath. ior: After the funeral.		27. Manner of Death 28a. Date of Ir (Month, Day	jury 28b. T ,Year) 28b. T				ow injury occurred	
Vis or At fiter d in by	Certification:	Z Accident investigation		m, street, factory, office b	ouilding, etc.	or Town, Sta	reet and Number or ate) 112 De Cumber1a:	Rural Route Number, City
Service and the state of the cause of the ca							(s) and manner as	stated.
T ₀ Wi	Me	and manner states 29b, Signature and title of certifier	1	29c. Licens • O.C.			29d. Date signed (
	F	30. Name and address of person who completed cause of					. 10 101111101 20,	
Sta	ite	Zabiullah Ali, M.D. Assistant Medical B 31. Date filed (Month, Day, Year) 32. Regist	Examiner 11 rar's Signature	1 Penn Street, Balt	timore, MD 212	201		
Registr	ar	DEC 0 4 2008	un St.	AND CE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 2008 SARAJANE TAYLOR YOUNG 2:36 A /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON 7320 MILLSTONE ROAD HANCOCK 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/21/1933 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F MISSISSIPPI 75 233-48-7159 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the finding Examiner must be not find at MD WASHINGTON HANCOCK Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 7320 MILLSTONE ROAD 21750 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ If Yes, Give Year or Dates: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be.
Department of Health and Mental Important: If then 27 is more any injury or other. WILLIAM TAYLOR VIVIAN GREENE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 562 CREEK ROAD, GLORIA J. YOUNG/DAUGHTER BERKELEY SPRINGS, WV 25411 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 24, 2008 ROSEDALE CEMETERY MARTINSBURG, WV 4 ☐ Donation 5 ☐ Other (Specify) BROWN FUNERAL HOME, P.O. BOX 821, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit be executed P.O. Box 68760, 53 Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ X o 3 Probably 4 ☐ Unknown s been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 □ No 1 ☐ Yes ospital or Attending Physiclan: The hours after death.
Ineral Director: After this certificate if filled in by the funeral director, pa 1∐Yes 2⊉ 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L Hospital 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M who completed cause of death (Item 23a) ype, Print)

Registrar
DHMH 17 Rev 1/2001

State

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32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Harry Arthur Zook ам November 14 2008 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, NOV 16 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 DXM 2 □ F 83 Director 219-14-7523 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If I them 27 is marked other than "natural" --- any injury or other traumatic exercises. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 TXNo MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Bond Street. 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No TATATT 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married WWIT If Yes, Give Year or Dates: 1 ☐Yes 2XNo Specify. þ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Westminster City Elementary/Secondary (0-12) 12 College (1-4or 5+) Police Officer Police Dept 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur A. Zook ပ Ruth Zincon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD John Zook/son 88 Sunshine Way 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westminster Cemetery 11/19/2008 Westminster, MD re of Funeral Service License Prietts Ferreral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that reased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician reel disease or condition resulting in death) Ele upon Myanoinan /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopo, performed : 2 ☐ No certificate 1 ☐ Yes 2 🗆 No 1 Yes funeral director, 25. Was case referred in medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of After 1 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending investigation Naturai
Accident nours after death.

neral Director: / 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier at Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mappier stated. (Check only onel 29b. Signature and title

State Registrar of certifi

completed cause of death

32. Regis

ar's Signature

30. Name and address of person who

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** O:35PM INDERSON 2008 /Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 3604 Grantley Rd Sex 7. Age (In yrs. last birthday) Himore ARE MATTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1**X**M 2□ F 87 421-20-8295 1921 North Carolina Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examinar must be notified at some. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 □ No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 3604 Grantley Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 42 — Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: black Completed by 42-46 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) administrator education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felix S. Anderson Bessie B. Bizzell မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Johnson/friend 2475 Etting Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Spacify) 21. Signature of Funeral Services licensee Ronald S Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street mi Baltimore, MD 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sudden /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2XNo 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this LIMNG After thi 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred t 💢 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State Registrar 29b. Signature and title of certifier

30. Name and address of person

DHMH 17 Rev 1/2001

empleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MHS

MD

29c. License number

29d. Date signed (Month, Day, Year)

Amend Items For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2, 3 Time of Death Physician Edna Rose Anderson 9:50 P.M 2008 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Howard Heartlands Assisted Living If Under 1 Year | If Under 24 Hrs. . Social Security Number 214 219-01-6349 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 😡 F Months Days Hours Director Aug. 4, 1910 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiter, must be notified at 10a State Director Maryland Howard Ellicott City 1 ☐ Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21042 3004 N. Ridge Road Apt H106 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify. Specify: ģ 3 HWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 7 Is marked other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental William Line Julia O'Brien ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 2224 Merion Pond; Woodstock, Maryland 21163 Joan B. Brandau Daughter permit. Pages 1 and Department of Health Important: If item 27 any injury or other tronce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/5/2008 Woodlawn, Maryland Woodlawn Cemetery 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee M01050 k Hademai MR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** THROMBOTIC STROKE /Medical Due to (or as a consequence of): Examiner ARTERIOSCUEROTTE DISEASE Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-trar CERTIFICATIO Due to (or as a consequence of): O. Box 68760. attending physician for use as the buria The law requires that the death certificate be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the and be detached for 1 ☐Yes 2 ☑No 9 Unknown 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown FRACTURE OF HIP 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No DEEP VELOUS THROMBOSIS 24a. Was an has autopsy performed? 1 Yes 2 No certificate PULMONARY THROMBOEKBOUSK Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?

12 Yes 2 2 10 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 ☐ Pending investigation Found: 7:00a. 07/20/2008 1 □Yes 2**X** No Subject fell. death. 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3004 N. Ridge Rd. Apt.Hl06,Ellicott City,MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOV. 04, 2008 30. Name and address of person who completed duse of death (Item 23a) (Type, Print) LAURENCE R. GALLAGER, MO 405 FREDERICK RD CATONSVILLE, MD 21228 31. Date filed (Month, Day, Year) DEC 0 5 2008 32 Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 1:35 PM November 25,2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE WAShington Modical ANNE AKUNDE 8. Date of Birth (Month, Day, Nov 27, 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours Months Days 1 □ M 2 🖾 F Maryland Nov Director 218-14-4964 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2√☐ No Director Anne Arundel Glen Burnie MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 USA 486 Lincoln Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: white Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

7 Is marked other than 'traumatic event, I'm. College (1-4or 5+) 4 Elementary/Secondary (0-12) 12 teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be John Denny Armstrong Agnes Tolson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Susan Derosier/daughter 801 Cedar Branch Drive Glen Burnie, MD 21061 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service Licenses Ronald S. W 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 complications that caused the death. Do not enter the mode of dying, such as cardiac or resultatory arrest, Approximate Interval Between Onset and Death Ala, Pa. 1. Enter the diserse, complications that shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) 61 **Physician** U 500minuH /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as/a consequence of); Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 D Ectopic pregnancy Year Month Day 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 240 1 ☐ Yes 1 □Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 1 1 1 1 1 Inpatient 2 DER/Outpatient 3 □ DOA After this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: At 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled filled 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar 31. Date filed (Month, Day, Year) DEC 05 2008

29b. Signature and title of certifier

30. Name and address

and manner stated.

of person who completed cause of eath (Item 23a) (Type, Print)

anbak

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

у В	oxdale,	Jr.	Dan	or State			viaryian 	Cer	tificate o	f Death			Reg. I	No.		3. Time of Death
	Physic		1. [ecedent's Name	e (First, Middle	e,Last)				_ ,	7	Mo De	nth Death cember 2	2008 Ye	ar	2012 hrs
	xam	ine		eroy Facility Name (i	of not institution	n nive etre	Gree	gory		Boxda 4b. City, Town,	or Location of D		00111001 2	4c. County	of Death	
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	Directo		2	13-23-	-5377	1 X M	2 F	19	Yr		ays i Hours	12	16	88	Co	ountry) MD
				ual Residence o	of Decedent			Ido- City	, Town or Loca	ation						10d. Inside City Limits
	v any	1	10:	a. State	10b. County			Tuc. City,								1 X Yes 2 No
4.44	Maryland 28a-f show	2	5	MD		IA			ват	imore	e		10g	Citizen of V	hat Cou	intry?
	Mary r 28a	Director	10	e. Street and Nu		7					21215			U.	S.A	•
	eath with the Maryland items 23a or 28a-f sho			. Marital Status		AVE 12	2. Was Dece	dent Ever in U	J.S. 13. W	/as Decedent of Yes, specify Cu	Hispanic Origin	n? (Specify	Yes or No-	14. Rac	ce - Amei ite, etc.	rican Indian, Black,
	eath w	Elinorial	1	X Never Marr	ried 2 N	narried 1	Armed For	2 X No				ruento i vicar	1, 0.0.7			Black
	ifter d	<u>ت</u> ا ا	_ 3	Widowed			es, Give Year Dates:			Yes 2 X		ind of work o	lone 1	Specify 6b. Kind of I		
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215-0036	e file ital Hy ked o	ent, th	a I	eroy (G. Box	(dal	e			ing Address (Deni	se Ro	DSS	er City or Ti	own Sta	te. Zip Code)
2	and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death and Mental Hygiene. (em 27 is marked ottler than "natural", or items 23a or 23a of 28a-5 sho tem 27 is marked ottler than "natural", or items 23a or 23a of 30 one 27 is marked ottler than "natural", or items 23a or 23a of 30 one 23 or 23a of	tic ev	<u> </u>	9a. Informant's N												
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5	es l au of He	or other traumatic event, the Medical Examiner	1	X Burial 2	Cremati	on 3	Removal fro	om State	crematory or	other place) emroia	l Dowl	12/	2/08	MOOG	al au	n. Md
ì	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the	0.00	-	Donation 1. Signature of I	5 Other	Specify:		K	ing M	emrora 2. Name and Ad arch F	dress of Facility	+	9/00	WOOC	A L CL W	
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7	vsicia	an	2	3a. Part I. Enter	the disease, only one caus	or complic	ations that c	aused the dea	th. Do not ent	er the mode of d	ying, such as ca	ardiac or res	piratory arre	st, shock, or	neart	Between Onset and Death
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	of Vital Records, ng Physician: The law require	After this certificate funeral director, page	٥	1 ✓ Yes 27. Manner of I	2 No			,			Bc. Injury at Wo	rk? 2	8d. Describe		ccurred	
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		들히				g Physici	an: To the b	est of my know	wledge, death	occurred at the	time, date and population, death	place, and d occurred at t	ue to the cau the time, date	se(s) and mages,	anner as and due	to the cause(s)
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	n			Tal	<u> </u>		19KL	ause of death	(Item 23a)							
	n			30. Name and Patricia	Aronica-P			stant Medic	cal Examin	er 111 Pe	enn Street, I	Baltimore	, MD 212	01		
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		_ For	Please	Type or Pri							•		_	e.	A 3	701
	•	State Registrar					Certifica	te of	Death		R	Reg. No.	200	ď	JJ	190
Physicia	an.	1. Decedent's Name	e (First, Middle, Las	st)							ite of Dear	Day			3. Time of I	Death
/Medic		Doroth		М.			1	Bu1			embe	_	, 2008		7:30	_a ^M _
Examin	er	4a. Facility Name (/	If not institution, give	e street and number)					r Location of De	eath			County of D			
Euraval	-	701 Card 5. Social Security N	olyn Road Jumber 6.8	ex 7. Ac	e (In yrs.	last birti	hday) If Und	er 1 Year	urnie If Under 24 F		te of Birth	h	nne A	Birthpla	ace (State of	r Foreign
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PL ,		Usual Residence of	f Decedent			Ŧ	1									1.55
arylar shov	'n	10a. State	10b. County		Tuc. Cit		or Location							10	d. Inside City1 □ Yes	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To E	Grover	C. Mott						Edr	na Rac	hel_	Grif	fin			
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that the ed by detac				contributing to death b	ut not res	ulting in	the underlying	cause giv	en in Part I.	2	3e. Did to	bacco u	se contribut	te to the	e cause of de	eath?
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ling P	ion:	27. Manner of Deat Natural	5 Pending	28a. Date of Inju (Month, Da	ury 1 <i>y, Year)</i>	28b. T Ir	jury	28c. Injui Wor		28d. D	escribe h	ow injur	y occurred			
death death stor: /	icat	2 ☐ Accident 3 ☐ Suicide	investigation 6		ury - At ho	ome far	M m street facto		Yes 2 □No	28f Lo	cation /C	troot on	d Number o	r Duml	Route Numb	har
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one)		nysician: To the best miner: On the basis of and manner st	of examina											
To the within To the Somple	Me	29b. Signature and	I title of certifier	1			2	9c. Licens	se number		2	29d. Dat	e signed (M	onth, D	ay, Year)	
,		ROMA	in S. Ka	intrioni	MI)	1	26	307			12	4/0	f		
		30. Name and addi	ress of person who	completed cause of	death (Iten	n 23a) (Type, Print)	71 -	20	1 ,_		-1	1 / -			a ^
		RAN S. 31, Date filed (Mon	KARIPIN	FN 3. Regist	102	ture	THE	16	KV,	dla	1) H	10	UM,	MI,	210	70
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [2] [] [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27^{Day} **Physician** 2008 Virginia M. Breidenstein 8:43 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11003 Grays Corner Rd. Berlin Worcester 8. Date of Birth (Month, Day, Year) 10/14/1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Hours 1□M 21 F Months Days 75 214-30-4533 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "matted Evon in the state of the state o Director 1 ☐ Yes 2 🛛 No MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 11003 Grays Corner Rd. 21811 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: white 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Hotel Benefits Coordinator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert M. Balducci Elizabeth E. Keil 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Pages 1 and 2 27 Gilland Court, Baltimore, MD 21236 Sandy Skipper /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State 10 Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service License 108 William St., Berlin, MD 21811 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 N Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident To the Hospital within 24 hours after death.
To the Funeral Director: After managed illed in by the further than the form of the further in t 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CW D 27 992 12-1-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month BANdORIC **Physician** illi Am 200 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MediCAL Center BALTIMORE DALHIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral t** M 2□ F 214-42-2090 Yrs. Director Feb. 10,1945 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ms 23a or 28a-f shov must be notified at 1 ☐ Yes 2 K No Westminster Director Carroll Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21157 United States 514 Old Westminster Pk. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Wes 2 □ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. natural", or items 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Never Married 2 4 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ò Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 Years Industrial Supplies Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barbara Howes William Bandorick ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7822 Jamesford Road Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type. Print) Mary Bandorick (Wife) Health a item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o NABurial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD Zakeview Mem. Park Cem. 12/5/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature uneral Service Licensee 22. Name and Address of Facility
Luda-Ruck Funeral Home of Dundalk, Inc. 21222 Dundalk, Maryland 7922 Wise Ave. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Esophageat ancer /Medical Due to ras a sequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine fo the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician a the burial Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed 1 Yes 2 🗹 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 Accident d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print) 30. Name and address of be

State Registrar 31. Date filed (Month, Day, Year

32. Registrar's Signature

10 NORTH C-REENESTREET BALTIMORE, MID 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 1304 8 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Maryland MANC MUCHENTU If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Country) est Virginia **Funeral** Days Min Months Hours 1 🔀 M 2 🗆 F Yrs West Director 64 217-42-6893 Oct. 31,1944 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expriner must be notified at 1 ☐ Yes 217 No **Funeral Director** Port Deposit Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21904 United States 766 Principio Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: Completed by White 3 ☐ Widowed 4 🖾 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Shipyard Worker Steel Industry 17. Father's Name (First, Middle, Last) Unkn. 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret L. Brennan ٩ 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Port Deposit, Maryland 21904 Mark Brennan (Son) 766 Principio Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o Important: If i any injury or once. = 8 Hilltop Service Corp. 12/1/2008 Towson, Maryland 4 Donation 5 Other (Specify) neral Seg 22 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk Inc. Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Zeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final MEUMONI **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) P.0. 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 10 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹Ño 2 ER/Outpatient 3 DOA 1 Inpatient this Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending Division 1 Natural 5 Pending 1 ☐ Yes 2 🗆 No investigation 2 Accident hours after death illed in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21190 Nov 2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 State Registrar

Year) Day, 0

Elizabeth Parker Frosch 32. Resistrar's Signature

22

S. Greene Street Baltimore MD

08-08665 Stacy Brogdon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certifica	ite of Death		Reg		90 337
Physicia	an/	Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death
ledical Exami	ner	Stacy		Brogdon	4.5	Month I November		0936 hrs
		4a. Facility Name (if not institution, give street Frederick Memorial Hospital	and number)	Frederick	Location of Death		4c. County of Deat Frederick	n.
		Social Security Number 6. Sex	7. Age (In yrs. last birth		ar If Under-24Hrs	8 Date of Birth		rthplace (State or Foreign
Funeral Director		Unk 1_M 2		Yrs. Months Day			. Co	ountry) Maryland
aus		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
*		Maryland	Freder	ick				1 X Yes 2 No
3 8 Aaryland 28a-f show Lat once.	ector	10e. Street and Number		10f. Zip Code		109	. Citizen of What Cou	untry?
the M	這	775 Wembly Drive A	pt. D	21701		τ	J.S.A.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho injury or other traumatic event, the Medical Examiner must be notified at once.	uneral	11. Marital Status 1 X Never Married 2 Married Ar	as Decedent Ever in U.S. med Forces?	13. Was Decedent of Hi If Yes, specify Cuba			14. Race - Ame White, etc.	rican Indian, Black,
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within yer the Medi	E C	10	Ho	omemaker	40 Mathada Nome	e (First, Middle, Ma	Domestic	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	17. Father's Name (First, Middle, Last) George T. Brogdon			Helen M		arden Surname)	
212 uld be Menta marrk		19a. Informant's Name/Relationship (Type, Pri	nt)	. Mailing Address (Stre			er, City or Town, Stat	e, Zip Code)
AD 2 sho h and 27 is		George W. Brogdon (Brother) 8	14 Elmine A	ve., Dur	ham, NC	27707	
e, F I and Healt Fitem		20a. Method of Disposition		f Disposition (Name of ce bry or other place)	emetery,	Date	20c. Location - City o	r Town, State
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Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	-	21. Lignature of Funeral Service Licensee		22. Name and Address Hanes Fune			Car and the	
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Physician /Medical		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.			, such as càrdiac d	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
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uted td ransit		events resulting in death) Last  Due to						
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Box e death c the atten ed for us	Physician	1 Yes 2 No 9 V Unknown 9	Pregnant at time of death 5 Unknown	Other (Specify)				
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tal Recolcian: The law certificate has	me					perform 1 ✓ Yes 2	ned? death?	
Vital Rec ysician: Thel his certificate   director, page	Be C	25. Was case referred to medical		26.Plac	e of Death (Check			
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n of ding Ph	T:U	1 Notural	a. Date of Injury 28b. T (Month, Day, Year)		ury at Work?	28d. Describe ho	w injury occurred	
Sior Attend r death rector: by the	atic	2 Accident investigation		8:46 am	Yes 2 X No	_		
Division of Vital Records, pital or Attending Physician: The law requir ours after death.  teral Director: After this certificate has been si filled in by the funeral director, page 2 should be	ertification:	Suicide A Could not be	e. Place of Injury - At home, fa	rm, street, factory, office amily apart		or Town, Sta	reet and Number of Rate) 775 Wemb	tural Route Number, City
Cospita lospita l hours unera	O	4 Homicide				Frederi		ated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	edical	one) 2 Medical Examiner: On the	the best of my knowledge, dea basis of examination and/or in					
To with	Мес	29b. Signature and title of certifier	anner stated	29c. Licen			29d. Date signed (M	
		( a rette	200000	o.c	.M.E.		November 20, 2	8008
		30. Name and address of person who complet	ed cause of death (Item 23a)					
0 '			· · · · · ·	Penn Street, Baltim	ore, MD 2120	)1		
		31. Date filed (Month, Day, Year)	82. Registrar's Signature	osk s				
Regis	1761	DEC 0 5 2008 🎜	Solution All All					

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 12:00 PM December 1, 2008 Clarence Nelson Burns Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** May 12, 1933 Pennsylvania 218-28-9256 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, If a IN-alical Expanie or must be in diffed at Director 1 ☐ Yes 2X No Bel Air Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Prospect Mill Road 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: þ Specify. Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 8 Gunner Foreman U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Matilda Elizabeth Burke Benjamin (nmn) Burns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Prospect Mill Rd., Bel Air, MD 21015 Elsie L. Burns / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdn. 12-5-08 Aberdeen, Maryland 21. Signature of Eungral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months' Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ ₩O 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 □ Yes 2 -NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | □ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner 28b. Time of 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

140,1

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O. Nesseen

and manner stated.

500 32. Registrar's Signature

Upper Che Sapeako Dr. Bel Air, MD 21014

29d, Date signed (Month, Day, Year)

Registrar

DEC 0 5 2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

H0062765

## 08-09082

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Donald Shane Brace	-	For State	Stat	te of Maryla	ind / Dep	oartment e <i>rtificate</i>	of l	Health Death	and	Menta	ıl Hyg		Reg. No.	2	669 222
	Re	gistrar Decedent's Name	(Eiret Middle	l act)			0/ /	- Journ		1.7		Date of Dea	ath -		3. Time of Death
Physician/ Medical Examine	r	Dona.	ld Sł	nane B	rady		141	o. City, Tov	un or Lo	cation of		Month Decembe		Year 08 County of Dea	2256 hrs
<b>1</b>	48	a. Facility Name (if Bayview Med			imber)		40	Baltimo		VIII.					
Funeral	5.	Social Security Nu	imber 6	. Sex	7. Age (In yr	s. last birthda	y)	If Under Months	1 Year Days	If Under	24Hrs. Min.			Fore	
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Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Seco	ndary (0-12)	2yrs	(1-4 or 5+)	Co	nt:	ract	or					11000	
5-0036 fled within 72 Hygiene. I other thau the Medical	<u></u>	17. Father's Name	First, Middle,						1	8. Mother's	Name (	First, Middle	e, Maiden	Surname)	
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Baltimore, ME permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	- 1	21. Signature of Fu	7	n. 1		1	l c	onne	11v	Fur	era	1 Hor	me o	f Ess	ex 21221
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Di spital neurs a neral i	Cert	4 Homicide	9	Physician: To the			oth on	oursed at the	ne time	date and r	olace and	d due to the	cause(s)	and manner a	is stated.
Division  Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the		29a. Certifier 1 (Check only one) 2		Physician: To the caminer:On the ba	e best of my kr asis of examin	nowledge, dea ation and/or i	nvesti	gation, in r	ny opinio	on, death	occurred	at the time,	date and	place, and due	e to the cause(s)
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$\sim$		30. Name and a	dress of pers	on who completed	cause of deal	th (Item 23a)						ID 0455	4		
$\emptyset$			Vincenti, I	MD Assista	nt Medical	Examiner	1	11 Penr	Stree	et, Baltir	nore, N	MD 2120	1		
s	tate	31. Date filed (M	onth, Day, Yea	3:	2. Registrar's	Signature	2246	وميد							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 D 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. 1 □ M 2 🗙 F 12/01/1924 219-22-3653 84 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 USA 4204 OLD MILFORD MILL ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🕍 No WHITE Specify: Specify: Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OFFICE ADMINISTRATOR PRINTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRIEDMAN ROSE CAPLAN LOUIS ည 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3312 SHELBURNE ROAD, BALTIMORE, MD BRIAN BERELE / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State BNAI ISRAEL CONG. 12/04/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Oronaru /Medical Due to (or as a consul ence of) Examiner Lus to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Physician: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ρ Month Day Year 5 Other (specify) ☐Yes 2☐No P.O. ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 dnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours after e Funeral Dire iletely filled in t 1 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and tile of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

State Registrar

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:45 AM romwel /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, + Rehabilitation Health Baltimore X+on Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **□ M** 2 □ F 80Yrs. 319 - 36 ~ 1575 Usual Residence of Decedent Maryland Director filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Des 2□No Kaltimore Director 10e. Street and Number 10g. Citizen of What Country? 21208 USA ane Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Yes 2 No f Yes, Give rear or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) ind Keeper П 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I ဂ 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Guardian ION 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation injury or 3 Removal from State Carme Important: if Baltimore, 4 □ Donation 5 □ Other (Specify) 21. Signature of Meral Service Licer 22. Name and Address of Facility towell Hants . MD 21207 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Brain A01, 714(. Physician disease or condition resulting in death) /Medical Due to (or as a sor sequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending properties of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second se IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Certification: To Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No funeral director, page 2 s certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA After this 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death. the f 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signatu 30. Name and address of person who completed cause of death Main St. CQ ARMS ACHAEI DNG 32 Registrar's Signature 31. Date filed (Month, Day, Year)
DEC 0 5 State Registrar

			For State Registrar		State of	Maryland	-	artment of H		Mental Hy	giene Reg. No.!	711118	33304
1	0 ,		1. Decedent's Name (Fig.	irst, Middle, La	st)					2. Date of De			3. Time of Death
	Physici /Medic		Ranbir_Ch	nibb							18/20		07:49 M
	Examin		4a. Facility Name (If not	t institution, giv	e street and num	ber)		4b. City, Town, o	r Location of Dea	th	4c.	County of Death	L
			Greater B					Towson If Under 1 Year	If Under 24 Hrs	S O Date of Bir		Baltimor	
ľ.	Funeral Director		5. Social Security Numb		M 2□F	'. Age (In yrs. las	Yrs.	Months Days	Hours Min	. (Month, Da			place (State or Foreign ntry)
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	rylan		10a. State 10t	b. County		10c. City, 1	Town or Lo	cation					10d. Inside City Limits
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03	ral', o	i by	3 Widowed 4	]Divorced	If Yes, Give Year or Dat	es:		1□Yes 2⊠No	Specify:			Specify: As	ian
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ary	2 should be and Mental is marked (		19a. Informant's Name/	/Relationship (			19b. Mailir	ng Address (Street	and Number or F	lural Route Numb	er, City o	r Town, State, Zij	Code)
Σ,	D = - =		Greater Ba		e Medica			N. Char	les Stre	- 44			
Baltimore, Maryland	ges 1 t of He if Itar or oth		20a. Method of Disposit 1 Burial 2 Cr		Removal from S	can	e of Dispo etery, crer	sition (Name of natory or other pla	ce)	Date	20c. Lo	cation - City or T	own, State
tim	t. Pag rtment rtent: njury		`4 □Donation 5 🛚			ate	1.0						
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	/Medical Examiner		resulting in death)	(	Due to (o	r as a consequer	nce of):						
		-i-	Sequentially list condition	ions,	b. Due to (o	r as a consequer	nce of):						
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Вох	eath certific attending p I for use as	Physician/Me	23b. Was decedent pre in the past 12 mon		1 Live bir	ome of pregnance th 2  Fetal de	eath 3	Ectopic pregnanc	/		2	23d. Date of deliv Month	ery Day Year
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<b>a</b>	res that th signed by be detac	by Pt	Part II. Other significan	nt conditions	contributing to dea	ath but not resulti	ng in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
rds	w require: been sig should be	q pa								1 🗆	Yes 2	<b>X</b> No 3□ Prol	pably 4 □Unknown
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Ä	Th ate pag	Com								perfe 1 ☐ Yes	ormed?	death?	
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Ö	s after	Certification:	4  Homicide	dotominod	buildin	g, etc. (Specify)				City or To	wn, State,	)	
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			1 Trans	m	D. A	en or		1.D D2	6112		11-	18-200	58
			30. Name and address	of person who				Print)					
			Norma V.		, M.D.	6565 N.	Char	les Stree	t Suite	309, Bal	Ltimo	re, MD 2	21204
	Sta Registi		31. Date filed (Month, D		1 1/1	gistrar's Signatur	0	ske)					
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	1	For State Registrar	State o	of Marylan		rtment of F			giene Reg. No.	2008	
Physician /Medical		Decedent's Name (First, Middle Clara L. Cole						2. Date of Dea Month Novembe	Day	, 2008	3. Time of Death 9:02 PMM
Examiner		la. Facility Name (If not institutio Harrison Seni	or Living	5		Snow			Wo	county of Death	
Funeral Director		5. Social Security Number  215-28-6076  Usual Residence of Decedent	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Date of Street) (Month, Date of Street)	v, Year)	Cour	place (State or Foreign htry) yland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		MD Worce			ry, Town or Lo	ke			10a Citiza	en of What Cour	0d. Inside City Limits 1 ☐ Yes 2 No
ed within 72 hours after death with the Man Sgiene.  er than "natural", or items 23a or 28a-f sh t, the Medical Examiner must be notified	ing in in	10e. Street and Number 409 Linden Ave 11. Marital Status		cedent Ever in U	.S. 13. V	10f. Zip Code  Was Decedent of H f Yes, specify Cub.	21851  dispanic Origin? (San. Mexican, Puer			USA  4. Race - Americ Black, White,	ean Indian,
hours after trural", or ite	en nà La	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 ☐ Yes If Yes, G Year or I	2A No live Dates:	16a. Deced	1 ☐ Yes 2 ☑ No	Specify:				hite
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Should be file and Mental Hy marked oth marked oth marked oth marked oth matic event	ŏ	17. Father's Name (First, Middle Charles Leo  19a. Informant's Name/Relation	nard Fisc	her		ng Address (Street	Clara and Number or R	a Belle	Winkl er, City or	Ler Town, State, Zip	o Code)
ore, Mar ges 1 and 2 sl t of Health an if item 27 is n		Laura Givens  20a. Method of Disposition  1 Burial 2 Cremation			Place of Dispo	ox 191 sition (Name of matory or other pla	New Chure	Date	23415 20c. Loc	eation - City or To	own, State
Dallillor permit. Pages Department of Important: If it any injury or o		4 ☑Donation 5 ☐ Other ( 21. Signature of Funeral Service RO na.L.d.		Virecto		2. Name and Addretate Anat	-		Bal	timore S	Street
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BOX of auth certification attending for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □Live	utcome pf pregr birth 2 □ Fet gnant at time of tnown	al death 3	□Ectopic pregnanc □ Other (specify)	y		2	3d. Date of deliv	ery Day Year
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Or VITA Physician: rthis certific ral director,	a R	25. Was case referred to medic examiner?	Hospital:			Ot		eath (Check only			
Phys ral di	tion: To	1 Yes 2 No  27. Manne of Death 1 Natural 5 Pend 2 Accident inves	28a. Dat	☐ Inpatient 2 ☐ te of Injury onth, Day Year)	28b. Time of Injury	of 28c. Inju	4 Mursing	Home 5 Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence			ffy)
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DIVIS To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by it	Medical	(Check only 2 Medical one)		he best of my kr basis of examir anner stated.	nowledge, dear nation and/or in	nvestigation, in my	opinion, death occ	ce, and due to the curred at the time	, date and	place, and due	to the cause(s)
To with Con	2	29b. Signature and title to berti	SARAD		-		54 4	22		e signed (Month)	-2008 3755)
Stat	e	30. Name and address of personal form of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the	cet St.	use of death (Ite	Enus	ke,	41) 21.	85/ (	410	-632-	3755)

DHMH 17 Rev 1/2001

Registrar

DEC 0 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #24a Per Verbal G886 12/08/08 JH

For Amend Item 25 Per me, 8886, 12/08/08 and of Health and Mental Hygiene 1 - For A State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Colbert, Jr. 10:10 A M Flovd November 11, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Goerge's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours 1√2 M 2□ F 220-28-6598 73 28. Director Feb. 1935 Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shorthe Medical Expriner must be notified at Maryland Prince George's Capitol Heights Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 501 Birchleaf Avenue 20743 United States r death v Completed by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 ₹ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itea may Injury or other traumatic event, the Medical Evertical Power. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2x No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 years Engineer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Floyd Colbert, Sr. Martha Thomas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Colbert - Daughter 7005 East Forest Road Landover, MD 20785 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Lee's Crematory Nov 29, 2008 4 □ Donation 5 □ Other (Specify) Clinton, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Linens 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Fatal Cardiac Arrythmia Physician /Medical Due to (or as a consequence of): Examiner Tentorial Subdura Hematoma due to Cerebral Smalls hitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Dieta iozasarconsesuence io: Examine Hospital or Attending Physician: The law requires that the death certificate be executed Vascular Disease Due to (or as a consequence of): physician as the burlat-t Division of Vital Records, P.O. Box 68760, Multiple Organ Failure Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Hypertension 24a. Was an autopsy performed? page 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examine. 14⊡ Yes <del>2 EXNo</del> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 🛮 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month Day, Year) 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Catevenis 3001 Hospital Drive Cheverly, MD 20785

State

Registrar

31. Date filed (Month, Day, Year)

DFC 0 5 2008

327 Registrar's Signature

		For State Registrar	State of Marylan	•	artment of F		ınd Me		giene Reg. No. 2	nns	3000
Physicia	an	1. Decedent's Name (First, Middle, Last)	COMPS		imouto or			Date of Dea Month	ith Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of	Death	scanla		2008 nty of Death	15:55 "
Funeral Director		210 01 010	7. Age (In yrs. 56	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day	v, Year)	Cour	place (State or Foreigntry) Land
Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltim		y, Town or Lo	cation Dunda	1k				1	0d. Inside City Limits
3a or 28	Funeral Director	10e. Street and Number 3216 Wallford D	rive		10f. Zip Code	21222	2		10g. Citizen o Unite	f What Cour d Stat	•
I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  I health and Mental Hygiene.  Other traumatic event, the marked of Examination must be mailed at the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of the marked of	þ	11. Marital Status  1 ☐ Never Married 2⊠ Married  3 ☐ Widowed 4 ☐ Divorced	I2. Was Decedent Ever in U. Armed Forces? 1 □ Yes <b>知</b> No If Yes, Give Year or Dates:		Vas Decedent of H fYes, specify Cuba I □Yes 2⊠No	lispanic Orig an, Mexican, Specify:	jin? (Specif Puerto Ric	y Yes or No- an, etc.)	14. R Bl	ace - Americ lack, White, o	
within 72 hou lene.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 9 Years	cation completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done of OO NOT use retired	oation during most d)	of working		16b. Kind of		
Lal ylallo 2.12 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the man	To Be C	17. Father's Name (First, Middle, Last) Charles K. Comb	S					irst, Middle, a Lara	Maiden Surna SON	ame)	
1 and 2 sho Health and Sm 27 Is m		19a. Informant's Name/Relationship (Ty) Mrs. Catherine V.	Combs (Wife)	3216	g Address (Street Wallford	Drive	e Dur	ndalk,	Maryl	and 21	.222
permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation Cremation 3 R  21. Signature of prefer Services Legisla	Oak	Lawn 22	sition (Name of natory or other place Cemetery Name and Addre Duda-Ruc 7922 Wise	12/6 ss of Facility		3		more,	Maryland
Physician		23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line.		er the mode of dyir		cardiac or re	espiratory ar			Approximate Interval Between Onset and Death
cate be executed bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of t	ence of):	tor NI	ATIC	N				36 HOURS
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3 □	Ectopic pregnanc Other (specify)	у				Date of delive	ery Day Year
quires that an signed b	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the un	nderlying cause giv	en in Part I.			bacco use co es 2 □ No		ne cause of death?
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di isi	ro Be	25. Was case referred to medical examiner?  1 Tyes 2 Tyo	ospital: 1 Inpatient 2 I	ER/Outpatien	t 3 DOA Oth	or:		theck only or 5 ☐ Resid	ne) ence 6 □C	Other (Specif	
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pital or At ours after d eral Direct		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	v) 				City or Tow	n, State)		al Route Number,
he Hos in 24 hc he Fun	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or inv	vestigation, in my c	me, date and ppinion, deat	h occurred	at the time, o	date and place	manner as s e, and due to	tated. the cause(s)
To t with To t	Σ	29b. Signature and title of certifier			29c. Licens		0.		29d. Date sign		
8		30. Name and address of person who co ARUNAS RAO M-D	mpleted cause of death (Item	123a) (Type, I	AVENU	E,B	AUTI	MORE	MD	212	24
Stat Registra		31. Date filed (Month, Day, Year)	32 registrar's Signa	ture		,		7			

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 9:40 A M DECEMBER 3, DENTS DAVID CANAVAN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford 201 Secretariat Drive Apt. Q Havre de Grace If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1[XM 2□ F 157-40-7867 60 Apr. 30, 1948 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 112 West Gordon Street 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Director of Land Use and Growth Management Elementary/Secondary (0-12) College (1-4or 5+) County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice Vincent Canavan Marie Rose Cavanaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara P. Canavan / Wife 112 West Gordon St., Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐Removal from State Hilltop Service Corp. 12-5-08 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic colorectal cancer 3 montes Due to (or as a consequence of) Sequentially list conditions, if any, leading to in regular cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 1 Yes 2**V** No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Residence 5 Pending investigation

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

the Medical

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12 should be filed w n and Mental Hygier is marked other th

permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is m any injury or other traum

72 hours after

Baltimore, Maryland 21215-0036

Box 68760,

P.O. |

Division or Vital Records,

Directo

Funeral

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1 Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only

29b. Signature and title of certifier ROUSE

after death filled in by To the Hospital or within 24 hours af To the Funeral D

d

State Registrar

DHMH 17 Rev 1/2001

ROISIN CONNOLLY 31. Date filed (Month, Day, Year)

MP

Injury

29c. License number RCS - 000

1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 12/04/08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Comply

MD 401 N. Broadway, Baltimore, MD 21231

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

6 Could not be determined



08-08920 Phyllis Capezio

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day November 27, 2008 2141 hrs Medical Examiner Phyllis Capezio 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death N/A 5307 Leith Road Apt. C **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) g. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral oreign Country) Months Days Hours Min. Director APR 8 1937 216-36-6374 71 PA М 2 **X**F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County s 23a or 28a-f show e notified at once. 1 X Yes 2 No N/A MD Baltimore Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21239 5307 Leith Road, Apt. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes White If Yes, Give Year or Dates: Yes 2 X No specify: Specify: Divorced Widowed ≥ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Clerk 12 Grocery Store 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Capezio Coviello Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N N 1938 Sue Creek Drive, Essex, Maryland Terry Koogle - niece 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 2 X Cremation 3 or other Burial Removal from State Department o Metro Crematory, Inc. 12/03/2008 Baltimore, MD Other Specify 21. Signature of Funeral Service Ligensee H. Cremation Society of Maryland, 299 Frederick Road, Baltimore, Williams 21228 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical e attending physician a. for use as the burial - t UNPENDED AMENDED The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✓ Unknown α Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown ₽. Completed Records, is been si should b 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has funeral director, page 2 sl performed? death? Yes 2 V No 2 No To the Hospital or Attending Physician: within 24 hours after death. 26. Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? Other Hospital: DOA Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 V Natural Yes 2 No Pending To the Funeral Director: filled in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. December 1, 2008

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

0

2008

Assistant Medical Examiner

32. Registrar's Signature

Ana Rubio MD.

31. Date filed (Month, Day, Year,

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Day Year **Physician** DORSEL PM ad 7:58 DECEMBER OI 2008 /Medical 4b. City, Town, of Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMOR AGNES HOSPITAL If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In,yrs, last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Hours Min. M 2□ F Months Days 6 Yrs. KAIC Director April Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, Ite Marical Examinar must be notified at Wes 2 No Director Ma. a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1- Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ne If Yes, Give Year or Dates: Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced a 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Guariam intena 12+6 RCHNICLES. Pages 1 and 2 should be filed went of Health and Mental Hyginner: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be mo a ပ 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Bucken Rid vak, mD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-8-08 atonsulle remelon 21. Sanature of Funeral Service Licensee 22. Name and Address of Facility fred clace Nancy M. Wallace and. 23a. Part 1. Enter the district ending see, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin **Physician** DAYS PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FIBRILLATION ATRIAL MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit FAILURG CONGESTIVE HEART physician and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) the 8 1 □Yes 2 □ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2**X**INo 1 □Yes 2 No 1 ☐ Yes Vital To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To o completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director; 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Terling Galuella KesitaenT
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 08 900S CATION 21229 AVE BALTIMORE EVELIN GATHECHA MD 31. Date filed (Month, Day, 92. Registrar's Signature Year) State 0 Registrar

ADFOR

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month Day Year 2:00 p M Gertrude Davis 3, 2008 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dundalk Genesis Eldercare- Heritage Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 24, 1923 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□M 2XF Hours 218-22-2999 85 **Director** Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1 ☐ Yes 2 ☐Xo Director Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9055 Bridget Lane 20646 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examines one. 1 ∐Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 years College (1-4or 5+) Tin Sorter Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Snavely Angeline McMillan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9055 Bridget Lane, LaPlata, Maryland Ronald Gilmore Davis son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 Burial 2 Cremation 3 Removal from State Gardens of Faith Cemetery 8, 2008 Rosedale, Maryland 4 Donation 5 Dother (Specify) 21. Sign wre of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician TIC CARDIDVASCULAR DISEASE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death
4☐Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 | Yes 21 Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place eath (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2V No Certification: To 2 ER/Outpatient 3□ DOA completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the 12/4/08 12/4/08 Marker 1/2022 5

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Vixon 08 latrici 2 /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Armole 1 If Under 24 Hrs. If Under 1 Year (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1 □ M 2**X** F 48 04/13/1960 Director Mississippi 524-92-2827 Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventral rust by mailing at Yes 2 ☐ No **Bowie** Director MD PG10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20716 2216 Hyde Lane U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 ☐ Widowed 4 反 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Masters Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Himportant: If item 27 is marked oth any Injury or other traumatic event Be Clarice McClelland John Henry Dixon II ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dante' Hodges - Son 8904 James A. Reed; Kansas City, Missouri 64138 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Paradise North Cenetery 12/06/2008 Houston, Texas 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Metustanc unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 11141 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed attending physician and for use as the burial-tran Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) □Yes 2 No ed by the Ö 9 Unknown signed by t d be detach ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed: certificate 1 ☐ Yes 2 💆 1 ☐ Yes 2 No al or Attending Physician: 's after death.
Il Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Division 1 💢 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

2

State

30. Name and address of

Mark 31. Date filed (Month, Day,

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Anapolis IMO

person who completed cause of death (Item 23a) (Type, Print)

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, ←

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DHMH 17 Rev 1/2001

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State of Manyland / Department of Health and Mental Hygiene

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imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	라	19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mailin	g Address (Str	eet and Num	ber or Rural F	Route Numb	er, City or T	own, State	e, Zip Code)
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Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Medical pages.	ŀ	21. Signature of Fu	ineral Service Li	censee		22.	Name and Addre	ess of Facility	McCom	nas Fu	neral	Home	e, P.A.
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	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	TORY FAIL		ac or respiratory	arrest,	Approxim Interval E Onset an
,60,	eath certificate be executed attending physician and for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con-	ARY HYPE sequence oi): ARY EM	BOLUS			
Division of Vital Records, P.O. Box 68760,	Attending Physician; The law requires that the death certificate be executed death, clear, After this certificate has been signed by the attending physician and sy the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3 Ectop	ic pregnancy (specify)		23d. Date o	
rds, P	quires that en signed t uld be dete	Š	Part II. Other significant conditions	contributing to death but not	resulting in the underlyin	g cause given in Part I.		tobacco use contribu ]Yes 2 ☐ No 3[	ite to the cause o
II Reco	pital or Attending Physician: The law requires tha ours after death. eral Director: After this certificate has been signed filled in by the funeral director, page 2 should be det	Completed					perl	opsy prio formed? dea	re autopsy finding or to completion o th? Yes 2 \( \square\) No
/ita	clan; ertific	Be	25. Was case referred to medical examiner?				ath (Check only	one)	
7	Physic this o		1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Res	sidence 6 ☐Other	(Specify)
sion o	ttending Pl death. ctor: After tl y the funeral	Certification: To	27. Manner of Death 1 X Natural 2 ☐ Accident 5 ☐ Pending investigatio		28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe	how injury occurred	
Divis	spital or Att ours after de neral Directe filled in by t	Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp	at home, farm, street, factecify)	tory, office	28f. Location City or To	(Street and Number o own, State)	or Rural Route N
	To the Hospi within 24 hou To the Funer completely fill	Medical	29a. Certifier 1 ☑ Certifying Pl (Check only one) 2 ☐ Medical Example (Check only one)	hysician: To the best of my miner: On the basis of examend manner stated.	knowledge, death occur nination and/or investigat	red at the time, date and place tion, in my opinion, death occ	ce, and due to the curred at the time	e cause(s) and mann e, date and place, and	er as stated. I due to the cause
	To t With Com	Σ	29b. Signature and title of certifier	) ,		D6798k	5	29d. Date signed (A	
_	Y		30. Name and address of person who	NAD 8600	OID GENE	GETOWN RD	BETHI	ESDA MD	20814
	Sta Regist	ar	31. Date filed (Month, Day, Year) DEC 0 5 2008	32. Registrar's Si	gnature				
DI	HMH 17 Rev 1/2	TUU							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Day Year November 24, 2008 Grace Voorhis Dillingham 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 10/16/1927 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1 □ M 2 🗷 F 81 Yrs. 064-22-8524 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815-United States 4601 N. Park Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Specify: White . Kind of Business/Industry Insurance den Surname) his ity or Town, State, Zip Code) . Location - City or Town, State Beltsville, Maryland Maryland 20910-Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year co use contribute to the cause of death? 2 No 3 Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? No 1 ☐ Yes 2 ☐ No e 6 ☐ Other (Specify) njury occurred t and Number or Rural Route Number, tate) e(s) and manner as stated. and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend of Maryland Peredatiment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death
Month
Day
Year
VOVEmber 24, 2008
4c. County of Death Eisenhar Physician Jeffrey アイン /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner upper chesapeake BelAir Harford If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 18 M 2□ F Days 193-38-5363 **Director** unknown Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits, ed other than "natural", or items 23a or 28a-f show event, it a Medical Examination at Cecil Director MD Kising 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2191 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 □ No
If Yes, Give
Year or Dates: UNKNOWN 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: White Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Sales Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be UNKNOWN unknowr ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Belair, MD South Main St. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 5/08 Millersburg 4 □ Donation 5 □ Other (Specify) Zion Lutheran Cemeter 22. Name and Address of Pogy New port Dr. Forest 1 till, mo 21050 21. Signature of Funeral Service Licenses Evans Funeral Chanel + Cremation Services-Belthr 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failufe. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (First disease or condition resulting in death) **Physician** Jeptre /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be twithin 24 hours after death.

To the Funeral Director: After this certificate has hoan sinned by the attending about the second of the funeral Director. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à arterial 2 No 3 Probably 4 Unknown Be Completed diseas 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autops perform 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 X Yes Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) November . 25, 2008 D 0063981 MD -30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Y. Lee, MD 669 Revolution St. Havre de Grace MP 21078

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 200 /Medical County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, Examiner Vie IMORL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 12, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Country)
Maryland 216-50-0116 1 ☐ M 2 💢 F 60 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside Cify Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Harford Edgewood Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 808 Truxton Court 21040 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: black 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wardell William Rochester Vivian Lorraine Horsey 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mercy Medical Center 301 St. Paul Place Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signature I Funeral S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, ΜĎ 23a. Party. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Immediate Cause (Final **Physician** a NONSmall 0 NICMUNT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and for use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 NO 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Inpatient 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 29, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar MMO 50

18-09064 Christopher Scot			oe or Print in ate of Maryla	and / Depa		f Health an			egible.	000 000
Physicia Medical Exami	n/	Registrar  1. Decedent's Name (First, Middl Christopher S			illicate of	Death		2. Date of De	Reg. No. eath Day Ye er 2, 2008	3. Time of Death 0708 hrs
Patrice		<ol> <li>Facility Name (if not institution</li> <li>Joppawood Court A</li> </ol>	•	ımber)		4b. City, Town, or Nottingham	Location of Death		4c. County Baltimo	of Death ore County
Funeral Director		5. Social Security Number 213 84 9915	6. Sex	7. Age (In yrs. la	ast birthday) Yrs	If Under 1 Yea	r If Under 24Hrs.	-	Birth(MM/DD/YYY er 9 1970	y) 9. Birthplace (State or Foreign Country) Maryland
<b>Baltimore, MD 21215-0036</b> $\mathcal{J}\mathcal{A}\mathcal{H}$ permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other transmatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	Usual Residence of Decedent  10a. State	arried 12. Was Dec Armed F 1 Yes or Code or Dates:  Cify only highest gra  College (** N/*  Last)  Sr  Chip (Type, Print)  Jr (Brothe:  1 3 Removal fr	Balt  cedent Ever in U. orces? 2 XX No ar de completed) 1-4 or 5+) A	16a. Deceder during m Constru	DUNTY  10f. Zip Code 21236 as Decedent of His res, specify Cubar  Yes 2 X No nt's Usual Occupa nost of working life  Uction Work  g Address (Street Ins Court  sition (Name of ce	spenic Origin? (Sp., Mexican, Puerto specify: tion (Give kind of v. DO NOT use retin KET  18.Mother's Name Shirley L et and Number or F Baltimore,	work done red)  (First, Middle Mort  Rural Route N Marylane Date	Specify: 16b. Kind of B Constante, Maiden Surnam  Lumber, City or Total 21237	e - American Indian, Black, te, etc.  White  Business/Industry  Uction
Physician /Medical -xaminer	Examiner	23a. Part I. Enter the disbese, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	complications that con each line.  a. Fenta: Due to (or as a b. Due to (or as a c.		Do not enter to exicati	7401 Belain the mode of dying	sof Facilians I Praid Home I Road Balt such as cardiac o iated wi	imore M		Between Onset and
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 University No 9 Atherosclero	23c. If yes, 1 Live I 4 Pregi g Unkn tions contributing t	outcome of pregi birth nant at time of de lown	pancy  2 For path 5 0  esulting in the	etal death 3 ther (Specify) underlying cause	E, g886	23e. Did 1	23d. Date of Month  d tobacco use con Yes 2 No 3 as an 24b. topsy rformed?	Day Year  tribute to the cause of death?  Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physiciau: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	edical Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  26. Place of Death (Check only one)  26. Place of Death (Check only one)  27. Manner of Death  1  Natural 5  Pending Investigation 3  Suicide 6  X  Could not be determined 1							1 ✓ Yes 2 No  ✓ Other: Scene  where or Rural Route Number, City ppawood Ct. ngham, MD  er as stated. Idue to the cause(s)  gned (Month, Day, Year)	
St Regis	ate		ant Medical Exa		Penn Stre	et, Baltimore,	MD 21201			

Registrar

			For State Registrar	State of Maryland	/ Depa	artment of F	lealth and I Death		ene 200	8 3332
	Physici		Decedent's Name (First, Middle, Last	Glenn M.	]	Fouse		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	•		4b. City, Town, or	r Location of Death		4c. County of Deal	
	Funeral Director		5. Social Security Number 6. Se 182–14–3237		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 2	Year) 9. Birt	thplace (State or Foreign funtry) nnsylvania
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, its Marical Examination at the confidence once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10c. Street and Number  1912 Walnut Av  11. Marital Status  1 Never Married  3 Widowed 4 Divorced  15. Decedent's Ed.  (Specify only highest grace)  Elementary/Secondary (0-12)  12 Years  17. Father's Name (First, Middle, Last)  Harry Fouse  19a. Informant's Name/Relationship (7)  Ms. Barbara Vance)  20a. Method of Disposition  1 Burial 2 Cremation 3 4  Donation 1 Other (Specify, 21. Single ture) Uneral Service of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State o	imore  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  12. Was 2 \( \) No If Yes, Give Year or Dates:  12. (cation le completed)  College (1-4or 5+)  12. (Daughter)  13. (Period)  14. (Period)  15. (Period)  16. (Period)  16. (Period)  17. (Period)  18. (Period)  18. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. (Period)  19. 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(Period)  19. (Period)  19. (Period)  19.	16a. Decec (Give life. L Die 19b. Mailir 191 ce of Dispo netery, cren	Dundal  Nas Decedent of H f Yes, specify Cuba I  Yes 2 No dent's Usual Occup kind of work done of NOT use retired Setter  Ig Address (Street 2 Walnut sition (Name of natory or other plac	21222  ispanic Origin? (Span, Mexican, Puerto Specify:  atton during most of work  18. 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Location - City or	ates rican Indian, e, etc.  White Industry  ustry  Zip Code) 222  Town, State  ium, MD
Box 68/60, 3	death certificate be executed  E attending physician and dor use as the burial-transit  Universely to the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the prop	ian/Medical Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequent of the death of the death of the cause on each line.  Due to (or as a consequent of the death of the death of the cause on each line.  Due to (or as a consequent of the death of the death of the cause of the death of the cause of the death of the death of the cause of the death of the cause of the death of the cause of the death of the death of the cause of the death of the cause of the death of the death of the cause of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the deat	Do not entrement of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t				23d. Date of del	- 7
L KeCOLGS, P.O. BO The law requires that the death	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions co  ASDESTOSIS  Hyperco	1 ☐ Yes	autopsy prior to completion of cause performed death?					
DIVISION OF VITAL R	To the Hospital or Attending Physician within 24 hours after deals. To the Funeral Director: After this certificompletely filled in by the funeral director	Certification: To Be	25. Was case referred to medical examiner?    Yes 2   No	Hospital: 1 ☐ Inpatient 2 ☐ EF	8b. Time of Injury	28d. Describe how	esidence 6 Other (Specify) be how injury occurred  (Street and Number or Rural Route Number.			
	the Hospitthin 24 hours the Funera	Medical C	one)	sician: To the best of my knowle ner: On the basis of examinatio and manner stated.	edge, death n and/or inv	estigation, in my o	pinion, death occur	and due to the ca	use(s) and manner as te and place, and due	stated. to the cause(s)
		2	29b. Signature and title of certifier  30. Name and address of person who co	Talle D.U.	20) (Time 1	29c. License	05599	2	d. Date signed (Month	
	√) Sta	te	De borah C. Gallo 31. Date filed (Month, Day Year) 5	0 100 1	Ich	Ave	Balhm.	~ MD	21222	
	Registra	ar	Mario C O	LUUU JESSEN	A.	STARLE S				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2008 NOV /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kalling Itimore Himore | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 10M 20 F Carolina 226-56-6803 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinations to be prefered as 1 Ves 2 No Be Completed by Funeral Director altimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 HINS 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☑No Specify: Specify: Back 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Brick layer 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Ideline ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Memoria 4 ☐ Donation S ☐ Other (Specify) 21. Signature Funeral Service 2120 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760, Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) his certificate has been signed by the a director, page 2 should be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by CARDIOVASCULAR DISCASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐Yes 2 ☐ No 2 Accident investigation 24 hours after death Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10059 11-27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 Burness CENTER REISTERSTOWN DMVE 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

			For State Registrar		State o	f Maryla	•	artment of <i>rtificate of</i>	Health and Death		giene Reg. No.	008	3882	2
			Decedent's Name (	First, Middle, Las	st)	_				2. Date of De	ath		3. Time of Dea	ath
	Physicia		Geneva	Carner						Novemb	Day er 24	Year 2008	2:00 P	PMM
	/Medic Examin		4a. Fecility Name (If n		street and nur	nber)		4b. City, Town,	or Location of Dea			County of Death		
H			333 Rus	sell Ave	enue #2	13		Gait	hersburg			lontgome	ry	
	Funeral		5. Social Security Nun		9x □M 21X7F		rs. last birthday,	Months Days	r If Under 24 Hr s Hours Mir	1. (Month, Da	th y, Year)	Cou	place (State or Fo intry)	preign
	Director		214-38-09 Usual Residence of D	30		10	08 Yrs.		<u> </u>	Sept 30	), 19	00   In	diana	
	and and			lob. County		10c.	City, Town or L	ocation					10d. Inside City Li	imits
	Mary f sho	jo	MD	Montgom	erv		Gaither	sburg					1 ☐ Yes 2	₹No
	28e	Director	10e. Street and Numb					10f. Zip Code			10g. Citiz	zen of What Cou	intry?	
	3e of		333 Russ	sell Ave	nue #21	3			20877			USA		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-1 show any injury or other treumatic event, Ite Madical Examinations to notified at ance.	by Funerai	11. Marital Status 1 □ Never Married 3 ◯ Widowed 4		12. Was Dece Armed Fo 1 Tes If Yes, Gin Year or D	orces? 2⊾No ve	1 U.S. 13.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X No	Hispanic Origin? ( ban, Mexican, Pue o Specify:	Specify Yes or No into Rican, etc.)		4. Race - Amer Black, White Specify: Wh	, etc.	
Ō	72 ho	Completed		5. Decedent's Ed			16a. Dece	edent's Usual Occ	upation e during most of w	orking	16b. Kin	nd of Business/la	ndustry	
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چ	d Mer narke	⁶	19a. Informant's Nam	Curtis S			19h Mail	ing Address (Stree	et and Number or F		er City or	Town State Zi	in Code)	
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altimore,	Pages 1 and of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of Heal of		20a. Method of Dispo 1 Burial 2 D	Cremation 3			o. Place of Disp cemetery, cre	osition (Name of nmatory or other p	lace)	Date	20c. Loc	cation - City or 1	own, State	
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387	physic sthe	dicai			_ d						-			
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	res thai igned b	y P	Part II. Other signific	1.00		_	9	underlying cause	given in Part I.	23e. Did	tobacco u		the cause of deat	
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Vital	icien: Th certificate rector, pag	Be C	25. Was case referre	ed to medical						eath (Check only				
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n O	ding P. After 1 funera	on:	27. Manuar of Death 1 Natural	5 Pending		of Injury oth, Day Yea	r) 28b. Time Injury	W	Vork?	28d. Describe	now injur	y occurred		0
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Division	or Al after of Direction by	Certification:	4  Homicide	determined	build	ling, etc. (Sp	ecity)	treet, factory, offic	.0		wn, State,			
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	ledical Co	29a. Certifier (Check only one)	Certifying Pl	miner: On the b	e best of my pasis of exam	knowledge, dea nination and/or	ath occurred at the nvestigation, in m	time, date and pla y opinion, death oc	ce, and due to the curred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)	
	o the	Me	29b. Signature and ti	itle of certifier				29c. Lice	ense number			e signed (Month		
	F > F 0		MAR	obert;	berry	What	Mes		4115				er 24,20	208
			30. Name and addre	ss of person who	completed cau	se of death of	(Item 23a) (Type	e, Print) 20	1 RUSS 11THER	SELL A SBURG	MEL	148	774	
	St	ate	31. Date filed (Month		32.1	Registrar's S	ignature							
	Regist	rar	DF1	0 5 200	18	1830 1	it for	ada)						
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**ORIGINAL** 

			For State of Maryla		rtment of F tificate of t		nentai Hy		
			Registrar  1. Decedent's Name (First, Middle, Last)		incate or i	Death	2. Date of De	Reg. No.	3. Time of Death
	Physici	an					Month	Day	Year
*	/Medic		Norman Leroy Grammer  4a. Facility Name (If not institution, give street and number)		4h City Town or	r Location of Death	Dece	nber 1, 4c. County of	2008 10:15 PM
	Examin	er	Upper Chesapeake Hospital		4b. City, lowil, or				
-	Francis			s. last birthday)	If Under 1 Year	Bel Air	8. Date of Bi	Harfo	9. Birthplace (State or Foreign
ţ	Funeral Director		212-42-5680 1DXM 2□F 6		Months Days	Hours Min.	(Month, D	ay, Year) 6/1944	Country) MD
	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or ftems 23a or 28a-f show other, the Medical Exhmitmer must be notified at		Usual Residence of Decedent  10a. State 10b. County 10c. 0	City, Town or Lo	cation				10d. Inside City Limits
	a-f s	Director	MD Harford	Joppa					1 □Yes 2 □No
	or 28	ire	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Country?
	th wil		110 Old Church Drive		21085			USA	
	dea sems	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or N	o- 14. Race	- American Indian,
9	after or It		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No		I∐Yes 2 No	Specify:	riidan, didiy		
8	ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					Specify:	White
N.	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	i (Give	lent's Usual Occup kind of work done o	durina most of work	ing	16b. Kind of Bus	•
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anc	ntal hed of	Be							3)
Ë	should be and Mental s marked o	ဥ	Norman Leroy Grammer, Sr.  19a. Informant's Name/Relationship (Type. Print)	405 14-15-		Dorothy			
Ma	d2sl than 7 is r traur		Debbie Grammer/Wife		-	and Number or Rui			
	1 and 2 Health em 27		· · · · · · · · · · · · · · · · · · ·			ch Drive	Joppa, Date		City or Town, State
altimbre,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Extensional traumatic event, the Medical Extensional traumatic event, the Medical Extensional traumatic event, the Medical Extensional traumatic event, the Medical Extensional traumatic event, the Medical Extensional traumatic event, the Medical Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extensional Extension Extensional Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Extension Ex		1 Dunial 2 Exclemation 3 Linemovaritom state		sition (Name of natory or other plac ake Crema	į	Dec 4 2008		lle, Maryland
Ball	permit. Departr Importa any Inji		21. Signature of Funeral Service Licensee MO 140	43		and Funer			e. Maryland
			23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician	- 1	Immediate Cause (Final disease or condition	Boo	1	1166			Onset and Death
	/Medical		resulting in death)  a. Due to (or as a conse	equence of):	V AV	ury			1145
-	Examiner		Cardi	ac A	rest				
	p. =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quanee of).	_ ^	,			
	ransi	Examiner	that initiated events c.	ardial	Intar	ction			1 Das
Ö,	e exe sian a urial-		resulting in death) Last  Due to (or as a conse	equence of):	, ,	) \			1.7
68760,	tificate be executed g physician and as the burial-transit	edical	d. Corona	ars H1	tery b	rsease			10 years
	± 50 6		IF FEMALE:						
O. Box	The law requires that the death cert site has been signed by the attending age 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 1% months?  1 ☐ Yes 2 ☐ To 9 ☐ Unknown	tal death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mon	e of delivery ith Day Year
σ,	that ned by deta		Part II. Other significant conditions contributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use contri	bute to the cause of death?
ဥ	w requires t s been signe should be	d by					1 🗆	Yes 2 No :	3 ☐ Probably 4 ☐ Unknown
Records,	s bee	lete					24a. Was	an 24b. W	/ere autopsy findings available
Re	The law cate has page 2 s	Completed					auto perf	ppsy prormed? de	rior to completion of cause of eath?
			25. Was case referred to medical			26. Place of Deat	1 Yes		□Yes 2□No
	Physician: this certification, partition	To Be	examiner? 1 Yes 2 No Hospital: 1 Impatient 2	☐ EB/Qutnatien	t 3 DOA Othe			idence 6 ☐Othe	r (Capily)
Division of	or Attending Physician: ifter death. Director: After this certific in by the funeral director, i	盲	27. Manner of Death 28a. Date of Injury	28b. Time of				how injury occurre	
<u>o</u>	nding F ath. r: After ie funera	aţio	1	Injury		Yes 2 No			
N S	Atte	iji iji	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office				or or Rural Route Number,
	tal or s afte al Dir ed in	Certification:	a Littornioldo Building, etc. (Spec	on <b>y</b> )			City or To	wn, State)	
	To the Hospital or Attendir within 24 hours after death.  To the Funeral Director: At completely filled in by the fu	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my king one Medical Examiner On the basis of examination and manner stated.	nowledge, death nation and/or inv	occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time	e cause(s) and mar , date and place, a	nner as stated. nd due to the cause(s)
	To the within To the Comp.	Me	29b. Signature and title of certifier		29c. License	e number		29d. Date signed	(Month, Day, Year)
			Marrie House		D4	0819		Decemb	her 1 2008
	2		30. Name and address of person who completed cause of death (Ite	em 23a) (Type, I	Print)			J	1,1,000
	) Sta		Marco Zamera Mu 31. Date filed (Month, Day, Year) 32. Bagistrar's Sign	500 nature	Upper Ch	esageake	Drive	Bel A	ir, 21014
	Registr		DEC 0 5 2008	H A	and a				

DHMH 17 Rev 1/2001

GRammer, Norman

		1	For State Registrer	of Marylan		partment of ertificate o				ne 008	33324
ì	Physicia	an	Decedent's Name (First, Middle, Last)	atherine	V. Gr	imes			Date of Death Month	Day Year 28, 2008	3. Time of Death
	/Medic Examin Funeral	er	Keswick MultiCare Cen  5. Social Security Number  6. Sex	ter 7. Age (In yrs.	last birthda	4b. City, Town Balti y) If Under 1 Ye	more	on of Death	Date of Birth (Month, Day, Y	N/A	-0.4.4
	Director	H	217–20–8689	86	Yrs.	Months Day	rs Hou		ay 11,		
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or	Location					10d. Inside City Limits
	Ba-fel	ector	MD N/A	I	Baltir	nore			100	g. Citizen of What Co	XX Yes 2 □ No
	sa or 2	Dir	10e. Street and Number 700 West 40th Street			212			100	U.S.A.	Suntry :
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Department of Heatilt and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show vary figury or other traumatic event, I'm Medical Examinat must be notified at once.	by Funeral Director	1 Never Married 2 Married 1 Yes	R. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates:		If Yes, specify C	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:			14. Race - Ame Black, Whi Specify: Wh	te, etc.
21215-0036	Athin 72 ho ne. hen "natur Medical	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12)  Colle	ted) ge (1-4or 5+)	(Gi	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker			16	16b. Kind of Business/Industry  Own Home	
Maryland 21	d be filed we antal Hygiei ced other to cevent, to	Be	12th  17. Father's Name (First, Middle, Last)  Earl	Davis Pa	almer			other's Name (F		Maiden Surname)	
ary	should and Me s mark	2	19a. Informant's Name/Relationship (Type, Print)		19b. Ma	iling Address (Stre	et and Nu	mber or Rural F	Route Number,	City or Town, State,	Zip Code)
e, S	1 and 2 1 ealth om 27 i		Joann Grimes (Daughte	20b. F	Place of Dis	Falls I		Baltimo	ore, MD	21211 Oc. Location - City or	Town, State
Baltimore,	Pages ment of h ant: If its ury or o		1 ☐ Burial 2 ☐ Semation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	_   0	lantio	c Crematory or other c	ory	12/2/0	08 (	Glen Burn	ie, MD
Balt	Dapart Import eny in		21. Signature of Funeral Service Licensee	1	1	3631 Fall	enss- ls Ro	Seitz Fi ad Bali	O. VO	Home, Inc. 21211	•
	Physician		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause Immediate Cause (Final	on each line.		_			espiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	e to (or as a conseq	uence of):	_ <u> </u>	CICI				
	uted A ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):							
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.O. Box 68	nt the death certificat by the attanding phy teched for use as th	Physician/Medi	in the past 12 months?	s, outcome of pregnative birth 2 Peta Pregnant at time of co	l death	3 □Ectopic pregna 5 □ Other (specify				23d. Date of de Month	elivery Day Year
۵.	uires thet the signed by a detection	ρ	Part II. Other significant conditions contributing HYPRYTERSION	sulting in the	ng in the disconying eache gives in that the				d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Tinknown		
of Vital Records,	The law requires thet sate has been signed b page 2 should be dete	Completed	Seizure DIGO	YDEY				<u> </u>	24a. Was an autopsy perform	prior to	
Vita	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	4.53	150/0		Other	Place of Death (			
ion of	on Affer Ing	ation: To	1 Yes 2 No Prospirat.  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 Date of Injury (Month, Day Year)	28b. Time Injur	e of 28c.	njury at Work? 1 □ Yes	28		nce 6 Other (Sp. vinjury occurred	ecity)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	3 Suicide 6 Could not be 28e.					28	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier Certifying Physicien: T (Check only one) 2 Medical Exeminer: On and	o the best of my know the basis of examina manner stated.	owiedge, de ation and/o	eath occurred at the rinvestigation, in r	e time, da ny opinion	te and place, an , death occurred	d due to the cal at the time, da	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
	To the within To the compl	Me	29b. Signaturi and title of certifier N M	0		29c. Lio	351	DZ_	D	d. Date signed (Mor	nth, Day, Year)
	/		30. Name and address of person who completed	e	m 23a) (Ty	cHaule	3 S	frict	Baltir	nore ma	anylano
4	St Regist	ate rar	31. Date filed (Month, Day, Year) DEC 0 5 2008	32. registrar's Sign	ature	fresh.					-

		1 - For State Registrar	State o	of Maryla	•	artment of F ctificate of		and Mental	, 0	0.6	20	0000
		Decedent's Name (First, Middle, Las	t)			timodito or .		2. Date	of Death	. No.	UK	3. Time of Death
Physicia /Medic	al	Mary C.		Hillian	cd	Al- Ola Taura	-1		mber	nber 01, 2008 9:		9:40 A M
Examin	er	4a. Facility Name (If not institution, give Longview Nursing					ester			-	roll	
Funeral Director		210-46-6803	ex □M 2241F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Date Min. (Mor.	of Birth oth, Day, Ye 29, 1	912	9. Birthp Coun Mary	lace (State or Foreigr try) 1and
be filed within 72 hours after death with the Maryland Ital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examination to motified at	Director	Usual Residence of Decedent	1		City, Town or Lo						10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
with th		10e. Street and Number	_		-	10f. Zip Code			"	. Citizen of	What Coun	try?
eath y	Funeral	1219 Old Manchest		d edent Ever in l	118 131	21157		nin? (Specify Vos		JSA	A maria	an Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination in other traumatic event, the Medical Examination in other traumatic event.	by	1 Never Married 2 Married  3 🖾 Widowed 4 Divorced	Armed Fo 1 ∐Yes If Yes, Gi Year or D	orces? 2⊠No ive							ck, White, e	etc.
ithin 72 ho ne. "natur Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (		16a. Deced (Give life. L	lent's Usual Occup kind of work done o OO NOT use retired	nt's Usual Occupation Ind of work done during most of working O NOT use retired)					lustry
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d be fi	) Be	17. Father's Name (First, Middle, Last)  Herbert King						r's Name <i>(First, N</i> da Marie			,	
shoul and Mi marl	2	19a. Informant's Name/Relationship (7	ype. Print)		19b. Mailir	g Address (Street						Code)
and 2 ealth a n 27 is er tra		Milton Hilliard,	Jr.			Old Manc						
t of He lifiten or oth		20a. Method of Disposition 1	Removal from		Place of Dispo cemetery, cren	sition (Name of natory or other plac	ce)	Date	200	c. Location -	City or To	wn, State
t. Pag rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify	)	Ciate		ne Park		2/5/2008				aryland
permi Depa Impo any fr		21. Signature of Funeral Service Licens		MOIO	50 Ft	Name and Addre	ss of Facility me of	Sterlin Catonsv	ıg Ash '111e,	nton S Inc.	chwab	Witzke
Physician // // // // // // // // // // // // //		23a. Part 1. Enter the disease, or compositors, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that one cause on e	caused the dea	ath. Do not ent	o30 Edmon	ng, such as	Avenue; cardiac or respira	Cator tory arrest,	svill	e, MI	Approximate Interval Between Onset and Death
Examiner			Due to	or as a conse	equence of):	-1	100	e ul	De	1000		204
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conse	equence of):	The V	- Cla		DE	sens	_	237
ificate be executed physician and sthe burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse	quence of);							
ificate g phys	edical	•	d									
The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live	tcome of pregr birth 2 Fet mant at time of nown	tal death 3	Ectopic pregnanc Other (specify)	у				te of delive	ry Day Year
w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions co	ntributing to d	eath but not re	sulting in the ur	iderlying cause give	en in Part I.	23e.	Did tobac	co use cont	ribute to th	e cause of death?
equires en sig									1 🗆 Yes	2KNo	3 Prob	ably 4 🗌 Unknown
Physician: The law re this certificate has be rail director, page 2 shc	Completed								Was an autopsy performed		prior to con death?	osy findings available npletion of cause of
sician certif rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Oth		of Death (Check				
g Phy er this eral di	2	27. Manner of Death	28a. Date	of Injury	☐ ER/Outpatien 28b. Time of	t 3 DOA 28c. Injur Work	4 ZS-Nur	rsing Home 5 28d. Des		e 6 Oth		")
ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Mon	ith, Day, Year)	Injury		k? Yes 2 □ N			, , , , , , , , , , , , , , , , , , , ,		
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, it	Certification:	3 Suicide 6 Could not be 4 Homicide determined	build	ing, etc. (Spec	cify)	eet, factory, office		City	or Town, S	tate)		Route Number,
he Hosp in 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one)  Certifying Phy 2☐ Medical Exam	iner: On the b	e best of my kr basis of examination bear stated.	nowledge, death nation and/or in	occurred at the tirvestigation, in my o	me, date and pinion, deat	d place, and due th occurred at the	to the caus time, date	se(s) and mand place,	anner as st and due to	ated. the cause(s)
Tot With Tot	Σ	29b. Signature and title of certifier	111.	+	_	29c. Licens				Date signe	1	
7	-	30. Name and address of person who co	Alle	In w	M 230) /T = 1	1)2	547	13	13	402	1200	8
10	ر		ompleted caus	3337 V	ictory	Print) DZ	mar	schoter	MD	211	02	

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per DVR G886 12/04/08 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 20, 2008 8:22 PM M Mary B. Hill /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel REgional Hospital Laurel 8. Date of Birth (Month, Day, Yea Dec 20, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Texas 6. Sex **Funeral** Hours Months Days 1 □ M 2 🛱 F Director 83 1924 458-24-1172 Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show the notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Director MD Montgomery Silver Spring 10e. Street and Number 10g, Citizen of What Country? and 2 should be filed within removed asith and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 3 m 27 is marked other than "hadical Examiner must be removed. 20906 USA 3152 Gracefield Road #606 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: white 1 ☐ Yes 2 No Specify: Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 self employed restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rawls Bolin Louise Janak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danealia D. Mineta/daughter 1631 Cliff Drive Edgewater, MD 21037 permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 MDonation 5 ☐ Other (Specify) 21. Signatur Peur ral Survice Wade, State and Address of Facility and 655 W. Baltimore Street 21201 +Baltimore, MD 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca se (Final disease or condition resulting in death) **Physician** ventricular arrhythmia /Medical Due to (or as a consequence of): Examiner atherosclerotic cardiovascular disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension, atrial fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 2000 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated

death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: completely filled in by the f ö

After

attending physician and for use as the burial-transit

filed within 72 hours after death with

1 and 2 Health tem 27 I

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

DEC 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugenio S. Machado Laurel Regional Hospital 2. Registrar's Signature

29c. License number

D24035

Laurel ,MD.

29d. Date signed (Month, Day, Year) Nov 21, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** SHE Frank Hamilton <u>10:</u>30₽^M 2008 <u>Decembe</u>r /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 35 Torque Way Baltimore Co. Middle River 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Funeral Hours Days Months 1 □ M 2√2 F 64 218-42-5240 12,1943 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, It = Medical Exaginar must be notified at Middle River 1 ☐Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21220 United States 35 Torque Way Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2K No Specify \$ Specify. 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 Years Registered Nurse Health Care Provider 12_Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Howell Kifer, Sr. ٥ McNew 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Torque Way Middle River, Maryland Dianna Kifer (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Md National Mem. Pk.Cem.12/6/2008 Laurel, Maryland 21. Signature of Pineral Service Co 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Likea 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** =KSANGUINATION /Medical Due to (or as a consequence of): **Examiner** CURRENT Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine RIMARY Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Yes 2 No 9 Unknown 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the Toneral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M. Auic Mg 2 DEC ZOOS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Dr. Balto MD 21257

Registrar DHMH 17 Rev 1/2001

State

Hamilton

9103

32, Registrar's Signature

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2008

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31. Date filed (Month, Day, Year)

Amend #2 per MD g886 12/5/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2008 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician Hamblin Dolly Deloris 23, 2006 6:30 A November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11209 Sandy Vale Road Baltimore Co. Kingsville 8. Date of Birth (Month Day Year) April 3,1937 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours Min. 1□ M 2 F Virginia 71 214-58-5080 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at Kingsville Baltimore 1 ☐ Yes 2X No Director Maryland 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò United States 21087 11209 Sandy Vale Road or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2/CXNo Specify: Specify: <u>≨</u> White 35 Widowed 4 ☐ Divorced "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; if Item 27 Is marked other the any Injury or other traumatic outcome. Homemaker 7 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Polly Prader Joseph C. Hess ပ္ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sally L. Underwood Kingsville, MD 21087 11209 Sandy Vale Road Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ***Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gdns. 11/26/2008 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head addure. List only one cause on each line. Approximate Interval Between Onset and Death Nalig Immediate Cause (Final disease or condition resulting in death) **Physician** moth /Medical Due to (or as a conse wence of) **Examiner** Sequentially list conditions Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed burial-transi and Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical the as esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nov. 24, 2008 024356 Malle eleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Franklin Sq. Drive BAlhimore MD ZIZS7 AM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2008 DEC 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2, 2008 DECEMBER 3:05 LOUISE JANET HASH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 2211 Williams Drive Havre de Grace Harford 8. Date of Birth (Month, Day, Ye If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) Funeral Months Days Hours 1 □ M 2 🛛 F Virginia 1940 68 Director 219-36-0202 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov "natural", or items 23a or 28a-f shovedcal Examiner must be notified at 1 ☐ Yes 2 🛣 No Directo Harford Havre de Grace Maryland 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or items 23a or: 21078 USA 2211 Williams Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sallie Belle Crouse ဥ James Leonard Morrison or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 438 Roberts Way, Aberdeen, MD 21001 Tina Pilarski / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: If ite any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 12-6-08 Hilltop Service Corp 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee in 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RA65 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it are the line to mind to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 ☐ Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign. **2** 2 1 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate 1□ Yes 2 🗹 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) : After thi 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Physician: To the Hospital or Attending death. after death.

Director: / within 24 hours a To the Funeral I

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Atwood Rd., Bel Air, MD 602 S.

Maria Carrillo, M.D 32. Registrar's Signature ^{Year)} 5 2008 31. Date filed (Month, Day, DEC 0

Please Type or Print in Black Indelible Ink. Ensure All/Copies Are Legible. Amend 10b & 10c per FH # 30 per DVR, g886 12/3/Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. -1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Robert Holler 1945 2008 Dec /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8700 Joney Mil mon Chevy Chase 10000 4 If Under 24 Hrs. 5. Social Security Number Date of Birth (Manth, Pay Year) 09/10/1911 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State of Foreign SCountry) Months Hours 577-18-3320 Usual Residence of Decedent 10c. City, Town or Location Washington 10a. State 10b. County 10d. Inside City Limits Director District Of Columbiashington 1 ☑Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3322 Military rd. 20015-Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 Nes 2 N If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1 ☐ Yes 2 ☒ No Specify ð 1943-46 Specify: Caucasian 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emory Holler Bessie Bynum ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Lee/Wife 3322 Military rd. Washington, DC 20015-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec 4 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory Inc.2008 Beltsville, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Rapp Funeral Facility 933 Gist Ave. Silver Spring, Maryland 20910-MO15 5 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to increase cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 PÑo 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 🔲 Natural 5 ☐ Pending Fa// investigation Nov 19 2008 0900 M 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7000 3000 85 Mil Rt, Chevy Chase, mp 20815 4 Homicide determined Home NVYSIZ 1St. Chevr Chase, mo 20% (
1St. Chevr Chase, mo 20% (
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Division of Vital Records, P.O. Box 68760, After this certificate has been signed by funeral director, page 2 should be detach After this within 24 hours after death To the Funeral Director: filled in by the

**Funeral** 

Director

Physician

/Medical

Examiner

State

Trung Bao, MD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

one

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

800, MD

10110 Molecular Dr #206, Rockville, MD 20850

29c. License number

DO0 5

29d. Date signed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December Year 2008 Lorraine Hashian 9:00 AM 2. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/04/1927 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 81 Months Days Min. 1 M 2 F Hours 017-22-3164 MA Director Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. Director Montgomery Bethesda 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9707 Old Georgetown rd. Apt#1502 20814-United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2KINo Specify. <u>م</u> Specify: Caucasian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Mental Health Elementary/Secondary (0-12) College (1-4or 5+) Therapist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Israel Levin ပ္ leborah Gayll 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thaddeus Hashian/Son 295 Lynnshore dr. U502 Lynn, MA 01902-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2/5/08 4 Donation 5 Dother (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility
Rapp Funeral & Cremation Services MOIS 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ongestive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rotound if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): law requires that the death certificate be executed burial-transit and Division of Vital Records, P.O. Box 68760, ~ resulting in death) Last Due to (or as a consequence of): physician s the burial Physiclan/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □Yes 2 ☑No Month Day Year 5 ☐ Other (specify) detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> icate has been siç ; page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1/1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 2 Accident 1 ☐Yes 2 ☐ No hin 24 hours after death the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only 29b. Signature and title of certifier ٥ 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Georgetown Id. Bethesday 10 31. Date filed (Month, Day, 3 Registrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:25A M Michelle Lynn Brady Hedrick 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/02/1971 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Funeral Months Days Hours Min 1 □ M 2 🖾 F 37 Maryland Director 216 70 3682 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 □ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 U.S.A. 3 W. Jeffrey Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 ☐Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify \$ Specify: 3 Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Valic Insurance Co. Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Harroll Goldie Douglas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trau 14 Talbot Street Baltimore, Maryland 21225 Goldie Harroll / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 12/03/2008 | Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. ranceoule 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) days /Medical Due to (or as a consequence of) Examiner days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) UNKNOWA Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) o ☐Yes 2 No 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturai 2 ☐ Accident 5 Pending investigation Injury s after death. 1 Yes 2 🗆 No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 29b. Signature and title of certifier

=ZINMA

31. Date filed (Month, Day, Year)

DEC 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BE

Registrar's Signature

DHMH 17 Rev 1/2001

INION

08-08734

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

loseph D. Howard	1-	For State	State	of Maryland		artment of <i>tificate of</i>		nd Menta	al Hyg		eg. No. 2	00	8 3383
Physician Medical Examine	/ 1	Decedent's Name  Joseph			II					Date of Deat		ır	3. Time of Death 1900 hrs
(		a. Facility Name (if	not institution, give	street and number)		1	4b. City, Town,			VOVEITIDE	4c. County of		5-31 (-)
Funeral	5	20412 Foxw  Social Security N	ood Terrace	x 7. Ag	e (In yrs. la	ast birthday)	Germanto		24Hrs. 8		th(MM/DD/YYYY	9. Birt	hplace (State or
Director		275–82–74	00	M 2 F	38	Yrs		ays Hours	Min.	07/09	/1970	Foreig Cou	n Germany
any	-	Isual Residence of 0a. State	Decedent 10b. County		10c. City,	, Town or Locat	ion						10d. Inside City Limits
\$	5	MD	Montgom	ery			Germant			U			1 Yes 2 XNo
he Maryland or 28a-f show	10101111	0e. Street and Nun 20412	Foxwood	Terrace			10f. Zip Code 208				0g. Citizen of WI		ntry?
s after death with rral", or items 23	by Funeral	3 Widowed	d 2 Married	If Yes, Give Year or Dates:	X No	1	as Decedent of Yes, specify Cub  Yes 2 X  nt's Usual Occu	oan, Mexican,	Puerto Rio	can, etc.)		e, etc. <b>Wh</b>	can Indian, Black,  ite
136 hin 72 hour ie. than "natu	Completed	Elementary/Seco		lly highest grade col College (1-4 or			Handym	ife. DO NOT			Const		
21215-0036 Juid be filed within 7 Mental Hygiene marked other than the event, the Medica	g [		David Ho	ward, Sr.		·		Do	nna	Harps			11
MD 21 id 2 should alth and Me m 27 is ma aumatic ev	<u>°</u>	9a. Informant's Na William(	me/Relationship (T Clarke /	_{ype, Print)} Stepfathe	r	19b. Mailin 34470	Scotch	reet and Num Lane	ther or Rur #1, V	ai Route Nui Villou	mber, City or Tov ghby Hi	vn, State 11s,	OH 44094
Baltimore, MD 21215. permit Pages I and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, th	1	4 Donation 5	Cremation 3	X Removal from S	^{tate} Mer	Place of Dispo crematory or o ntor Ce	metery		11/29	•	20c. Location Mento	r, o	H
Balt permit Departi Import injury	- 1	1	me Xa 1	see Dorota  Moudinications that cause	Luca 1	V/ 1	1501 Ea	st for	t Ave	enue,	Baltimo	re,	MD 21230 Approximate Interval
Physician 'Medical ( :aminer	1	23a. Part I. Enter th failure. List on Immediate Cause ( or condition resulti	ly one cause on ea Final disease a.	nch line. Narcotic	into	xicatio		ng, such as ca	ardiac or re	espiratory ar	1631, 31100K, 01 116	Sait	Between Onset and Death
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	E۱	if any, leading to in cause. Enter Unde (Disease or injury t	rlying Cause	Due to (or as a cons							1925		
uted id ansit		events resulting in		Due to (or as a cons	-								
o, e be executed ysician and burial - transit	edical	X UNPENDED		AMENDED 23			per ME	g886 .	12/9/ ———	08 TT ———	1		
6876 certificat nding ph	ΣΙ	IF FEMALE: 3b. Was decedent past 12 months	?	23c. If yes, outco		2 F	etal death Other (Specify)	3 Ectopio	c pregnanc	Су	23d. Date of Month		y Day Year
D. BC	ᇍ	Part II. Other sign		9 Olikilowii	ith but not	resulting in the	underlying cau	se given in Pa	art I.	23e. Did			the cause of death?
S, P.	ed by						<u></u>			1 Y			bably 4  Unknown utopsy findings available
2 a a 2	Complet									auto perf 1 🗸 Yes	opsy formed?		completion of cause of
Vital Rec hysician: The this certificate I director, page	8	25. Was case referexaminer?	_	Hospital: 1 Inpat	ient 2	ER/Outpatier		Other		Home 5	Residence 6	<b>✓</b> Othe	er: Scene
n of V ding Phy After th funeral c	일: 19	1 ✓ Yes 27. Manner of Dea 1 Natural	2 No th	28a. Date of Ir (Month, Day	jury ,Year)	28b. Time of		Injury at Work	. 1	28d. Describe	e how injury occu	rred	
Division  pital or Attend ours after death teral Director: filled in by the	Certification:	2 Accident 3 Suicide	Investigate  6 X Could not determine	be 28e. Place of	Injury - At	B FD 6:3 home, farm, str dence	3∪ pm,		10 2	28f. Location or Town, German	(Street and Num State) 2041 ntown, M	ber or R 2 Fo	ural Route Number, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	4 Homicide 29a. Certifier (Check only one) 2	Certifying Physic Medical Examine	cian: To the best of r:On the basis of ex and manner state	amination	edge, death occ and/or investig	urred at the time ation, in my opi	e, date and planion, death or	ace, and d	lue to the ca	use(s) and mann	er as sta	ted.
F. 2 F. 8	Me	29b. Signature and	title of certifier	A /				ense number	OGME		29d. Date sig	·	onth, Day, Year)
24	-			completed cause o			)					,	
2		Theodore N 31. Date filed (Mor	M. King, Jr., Mi	D. Assistant			111 Penn	Street, Ba	altimore,	, MD 212	01		<del></del>
Sta Registi		n E	0 5 200	8		S. S. S. S. S. S. S. S. S. S. S. S. S. S	line !						

Physician /Medical Examine

**Funeral** Director

Medical Certification: To Be Completed by Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, State DEC 0 5 2008 Registrar DHMH 17 Rev 1/2001 ORIGINAL

	for State Registrar		State of M	aryland	l / Depa <i>Cei</i>	artment of I rtificate of	lealth a Death	and Me		giene / Reg. No.	200	3 3 3 3 3 3		
	Decedent's Name (	(First, Middle,	Last)						2. Date of Dea			3. Time of Death		
n	Pamela	Ann	Hengemi	h1e				İ	Month	3 Day	2008	7 1430 PM		
r	4a. Facility Name (If r		give street and number			4b. City, Town, o	r Location of	f Death		4c. Cc	ounty of Dea			
Ī	5. Social Security Nur 219–76–43	mbel (	6. Sex 7. Ag	ge (In yrs. la. 48	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min	8. Date of Birt (Month, Da DEC 1	th y, Year) 1959	Co	thplace (State or Foreign ountry)		
	Usual Residence of D			140. 00	T							10d. Inside City Limits		
_		10b. County	imore		Town or Lo	cation						1 ☐ Yes 2 🛣 No		
eci	MD		rmore	E	ssex	10f Zin Code								
5	10e. Street and Numb		Wonne			10f. Zip Code 2122	ı	10g. Citizen of What Country?  USA						
eLa	11. Marital Status	sach F	12. Was Decedent	Ever in U.S.	13.			nin? (Spec	cify Yes or No	- 14		erican Indian,		
be completed by runeral Director	1 Mever Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married Forces?  1 Merce Forces 1 Never Married Forces?  1 Never Married Forces?  1 Never Married Forces?  1 Never Married Forces?  1 Never Married Forces?  1 Never Married Forces?  1 Never Married Forces?  1 Never Married Forces?					13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☒ No Specify:						e, etc.		
пріетес	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								16b. Kind	of Business	/Industry			
5			4		Nur	se					ical			
e D	17. Father's Name (F								(First, Middle,					
2	Daniel		ngemihle				Cat	heri	ine	Schm	idt			
			^{p (Type. Print)} life Ques — part			ng Address <i>(Street</i> <b>Beach Av</b> e				er, City or To 2122]		Zip Code)		
	20a. Method of Dispo 1 Durial 2 4 Donation 5	Cremation 3	∃ ☐ Removal from State	1		sition (Name of matory or other pla		2/02			tion - City or Ltimor	Town, State		
	21. Signature of Fund	eral Sewice Li	en Will	iams	22	Name and Addre Cremation 299 Fred	ss of Facility  Soci	ety (	of Mary	vland.	Inc.			
cal Examiner	disease or condition resulting in death)  Sequentially list cond if any, leading to mind cause. Enter Underly Cause (Disease or in that initiated events resulting in death) La	ving jury	b. ARD Due to (or as b. SOPE S Due to (or as d. Sope S)	а сопъецие	лісь Лј.	ТОРАП								
Medical Certification; To be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 9 □ Unknown	onths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 Fetal o	death 3[	☐ Ectopic pregnand ☐ Other (specify) _	у			230	d. Date of de Month	livery Day Year		
a by rii	Part II. Other signific	ant condition	as contributing to death to	acute	ting in the u	nderlying cause giv	en in Part I.		23e. Did to			o the cause of death?		
Complete	colitis								24a. Was autop perfo 1 □ Yes		prior to death?	utopsy findings available completion of cause of		
0	25. Was case referrex		Hospital:	_		oth	or.		(Check only o					
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alcal (	29a. Certifier 1 (Check only 2 one)	☐ Certifying☐ Medical E	Physician: To the best xaminer: On the basis and manner si	of examination	ledge, deat on and/or in	h occurred at the tovestigation, in my	me, date and opinion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) ar date and pl	nd manner a ace, and due	s stated. e to the cause(s)		
Me	29b. Signature and tit	tle of certifier	100th	M	D	29c. Licens	e number			29d. Date s		th, Day, Year)		
	30. Name and address	S CC C	ho completed cause of		OFICE	Print) NKlin Squ	are D	or.B	attimo			237		

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			For State Registrar	State of Ma	aryland / L	_	rtment of H tificate of L		Mental Hy	/gien Reg. N	2000	3 3 3 3 3 3	
	Dhysisi	<b></b>	1. Decedent's Name (First, Middle, Las	t)					2. Date of D		ay Year	3. Time of Death	
	Physici /Medic		Mildred	Harri	son				Dec.	2,	2008	10 P M	
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or		4	4c. County of Death			
	<u> </u>		Lorien at Fran  5. Social Securify Number 6. S		rsing e (In yrs. last bir		Balt. If Under 1 Year	imore If Under 24 Hrs.	8 Date of Bi	irth	n/a	3 irthplace (State or Foreign	
ì	Funeral Director			ом 20 F 9.		Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D Sept. 2	ay, Year 22 <b>,</b> ]		Maryland	
	land ow rt		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	cation					10d. Inside City Limits	
	Mary I-f sh	ţo	MD n/a		]	Bal	timore					1 □ Yes 2 □ No X	
	n the	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What C		
	th wit 23a o 1st be	al D	2042 Cliftwood	l Ave.			2121	3		τ	JSA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 1 If Yes, Give Year or Dates:			Vas Decedent of Hi fYes, specify Cuba ☐ Yes 2☐ <b>X</b> ∫o	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - American Indian, Black, White, etc.  Specify: BLACK		
Maryland 21215-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Deced	ent's Usual Occupa kind of work done d OO NOT use retired	king	16b.	Kind of Busines	s/Industry		
12	within ene. than "	Juple	Elementary/Secondary (0-12)	College (1-4or 5			00 NOT use retired; orer	3		Gr	Orrous	S Point	
<b>q</b>	filed Hygi other	ပို	10th 17. Father's Name (First, Middle, Last)	<u> </u>			0101	18. Mother's Nan	ne (First, Middle			POTITE	
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ary	2 should be and Mental is marked of raumatic ev	_	19a. Informant's Name/Relationship (7	ype. Print)	19b	. Mailin	g Address (Street a	nd Number or Ru	ıral Route Numi	ber, City	or Town, State,	Zip Code)	
	1 and 2 Health a em 27 is		Cynthia Dougla	s (grand	daugh	nte	r) 4203	Eldone	Rd. E	Balt	o,Md.	21229	
timore,	of He of He or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of cemete	f Dispos ry, cren	sition (Name of natory or other place	e)	Date	20c. l	Location - City o	or Town, State	
Ĕ	Pages ment of H ant: If ite	0 3	4 □ Denation 5 □ Other (Specify	')	Balti	imo	re Cemet	erv De	c.8.20	0.8	Balto.	Md 5M	
Ball	permit. Departm Importa any Inju		21. Signs ture of Funeral Service Licen	see /		22 Ca	Name and Addres	s of Facility	as Fun	ora	1 Homo		
	4112 60		100 Mayer	11.100	rugg	114	alvin B. 412 E. F	reston	St. B	alt	o, Md.	21213 Approximate	
		8 8	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final						or respiratory a	arrest,		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a.	STA Q		demo	MT LA .					
	Examiner			Due to (or as	a consequence	ot):							
	a la	Je.	Sequentially list conditions, cause. Enter Underlying	b. Due to (or as	a consequence	of):							
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Ö,	e exe ian ar urial-t	EX	resulting in death) Last	Due to (or as	a consequence	of):							
68760,	ficate be executed physician and is the burial-transit	edical		.d									
Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown				23d. Date of delivery  Month Day Yea						
Vital Records, P.O.	uires that n signed by Id be deta	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	n the un	derlying cause give	n in Part I.				to the cause of death?	
OS	law rec as beer 2 shou	Completed	prohable	! Colon	car	/UV	nomA.		24a. Was		24b. Were a	autopsy findings available	
ř	sician: The la certificate has rector, page 2	Com							perf	opsy formed? 2 \ N	death? lo 1 ☐ Ye	completion of cause of es 2 1 No	
VII:	ician; sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oah -	26. Place of Dea				<u> </u>	
ō	ding Phys	2	1 ☐ Yes 20 No 27. Manner of Death	1 ☐ Inpatie	ent 2 ER/Ou	tpatient Time of		4 La Nursing H			6 □Other (Sp	ecify)	
O	d <b>ing</b> h. After funei	lion	1 Natural 5 Pending 2 Accident investigation	(Month, Da		Injury	28c. Injury Work	es 2 □ No	28d. Describe	riow mj	ury occurred		
Division or	Atten	fica	3 Suicide 6 Could not be	28e. Place of inju		ırm, stre	eet, factory, office		28f. Location	(Street a	and Number or F	Rural Route Number,	
á	s after s after al Dire	Certification:	4 Homicide determined	building, et	c. (Specity)				City or To	own, Sta	te)		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one) 1 Certifying Ph	yslcian: To the best niner: On the basis o and manner sta	f examination ar	e, death	occurred at the tim restigation, in my op	e, date and place pinion, death occu	e, and due to the erred at the time	e cause( e, date a	(s) and manner and du	as stated. ue to the cause(s)	
	To the within To the Comp	Me	29b. Signature and title of certifier	2000			29c. License				ate signed (Mor		
			March	0,W U				5102				3,2008	
-	7		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, F	CILANI LA	Strit	BALL	mn	n man	MAND	
	Sta	te	31. Date filed (Month, Day, Year)					JITCH	174661	(0		T CPC TO C	
	Registr	_	DEC 0 5 200	18	ar's Signeture	100	1						

DHMH 17 Rev 1/2001

Amend 18 per Fh 8866 12/17/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	of Maryland		artment of I Tificate of		d Mental H	lygiene Reg. No.	2008	33337		
			1. Decedent's Name (First, Middl	le, Last)					2. Date of Month	Death , Day	Year	3. Time of Death		
	Physicia /Medic		Lillie		Mav		Jone	25	Decem	bee	7:34 AM			
in.	Examin	٠.,	4a. Facility Name (If not institution	n, give street and nu	ımber)			or Location of De	eath	4c.	County of Deatl			
			Union Memori		~	11:41 1:13		imore	re la Data at	Dinth	O Diet	ulas (Otata as Fasaina		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2√2 F	7. Age (In yrs. la	st birthday) Yrs.	Months Days		in. (Month,	Day, Year)	Co	nplace (State or Foreign untry)		
	Director	1	218-48-0559 Usual Residence of Decedent	Δ.	62			1	09 1	9 4	0	MD		
	yland yow		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits		
	a-fsl	ctor	MD N	A		Balt	imore					1 XYes 2 □ No		
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citi:	zen of What Co	untry?		
	ath w		3504 Dudley	Ave			213				U.S.A			
	er de items	Funeral	11. Marital Status	Armed F	edent Ever in U.S. orces? 2 1 No	.   13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or lerto Rican, etc.)	No-	<ol> <li>Race - Amer</li> <li>Black, White</li> </ol>			
36	rs aft	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes. G	ive 23		I⊡Yes 2√ No	Specify:			Specify: B.	lack		
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the flested Examiner must be norified at	ted	15. Deceder	nt's Education	- 1		dent's Usual Occu			16b. Kir	nd of Business/I	ndustry		
215	hin 7.	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (	1-4or 5+)	life.	kind of work done DO NOT use retire	auring most of v ed)	vorking	Ba.	ltimor	e City		
	filed wit Hygien other th ent, the	S	12th grade	na		Pa	ra Proi				olic S	chools		
pu	be fill ntal H rd oth	Be	17. Father's Name (First, Middle,	,					Name (First, Mido		,			
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<u>ئ</u>	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		Jack Jones-H 20a, Method of Disposition	uspand	20b. Pla	35U4 ace of Dispo	Dudley sition (Name of natory or other pla	Ave	Date Date		cation - City or			
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∄	nit. F artm ortar injur		4 Donation 5 Other (Specify) King Memorial Park 12/9/08 Woodlawn, Md  21. Signature of Funeral Service Licensee March F/H West											
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-	Physician	7 1	disease or condition resulting death)  - a. Conject at Heart Failure  Onset and Death  Signar  Onset and Death											
	/Medical		resulting in death)	Due to	(or as a conseque	ence of):	120-00					,		
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7	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a conseque	ence of): *		40				4)4		
/	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to	cute K		& Fail	we				1 years		
8760,	cate be executed physician and the burial-transit	dical E			,	,								
687	ificate g phy ts the	edic		u										
Box	death certific e attending p d for use as	M/u	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnan		☐ Ectopic pregnan	.0.,		2	23d. Date of deli	very		
	0 0 0	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No		gnant at time of de		Other (specify)			_	Month	Day Year		
P.0	at the i by th stache	چ	9 🗆 Unknown											
	The law requires that the de ate has been signed by the spage 2 should be detached for	þ	Part II. Other significant conditi	ons contributing to	death but not resul	ting in the u	nderlying cause gi	ven in Part I.			se contribute to □ No 3 □ Pr	the cause of death?		
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3ec	e law has t je 2 s	mple I							– 24a. W	as an utopsy erformed? 🚄	24b. Were au prior to death?	topsy findings available completion of cause of		
a									1 □ Ye	s 2 12 No		2 🗆 No		
Ζ		Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hoopital		D/O-44	. all pos ot	hor:	Death (Check on					
o	Phys er this eral di	Ë.	27. Manner of Death	28a. Date	e of Injury	28b. Time o	IL 3 LI DOA	4 LI Nursin	g Home 5 R			cify)		
on	Attending r death. ector: After by the funer	ţi	1 Natural 5 ☐ Pendii 2 ☐ Accident investi	ng ( <i>Mo</i> . igation	nth, Day, Year)	Injury		rk? ∃Yes 2⊟No						
Division of Vital Records,	Atter	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ningal   200. Flac	e of Injury - At hon ding, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location	n (Street an Town, State	d Number or Ru	ral Route Number,		
Ö	s afte	Certification: To	4 El Homicide	Bolle	ang, etc. (opcony)				Ony or	rown, blate,	,			
	To the Hospital or Attending Phywithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral	Medical	29a. Certifier 1 ☐ Certifyi (Check only one) 2 ☐ Medical	ng Physician: To the	basis of examinati	rledge, deat ion and/or ir	h occurred at the vestigation, in my	time, date and pl opinion, death o	lace, and due to occurred at the tin	the cause(s) ne, date and	and manner as place, and due	stated. to the cause(s)		
	To the within 2 To the comple	Mec	29b. Signature and title of certific		nner stated.		29c. Licen	ise number		29d. Dat	te signed (Monti	n, Day, Year)		
	F S F O		mao	1111	Nu		ATO	428 Gu	6-145	Doce	nber	3,2008		
	9		30. Name and address of person	who completed cau	use of death (Item	23a) (Type,	Print)	730 19	v 113	0000				
	8		Melanie	Germi		ρ.	Unior	Men	norral	Ho	Spital	3,2008 1, M.P.		
	Sta		31. Date filed (Month, Day, Year,	1 1	Registrar/s Signatu	ure /					1	,		
	Registr	ar	DEC 0 5	5 2008   2	Betteda o his		0000 1							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 10:188 **Physician** 9. Vovember 8, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner memorial imore 1100 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 244-68-3139 Months Days Hours Yrs may 15 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 es 2 No Timore Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1608 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 0 ဥ a 19a. Informant's Nam-/Relationship (Type. 19b. Mailing Address (Street and Number or Rural oute Number, City or Town, State, Zip Cod.) Son Joynes 21223 auid Í eto, no W 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 11-28-08 4 ☐ Donation 5 ☐ Other (Specify) 270 Fre attILTO 21. Signature of Funeral Service Lig 22. Name and Address of incility ch Fitt. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death e disease, or com failure. List only Part1 ter the diseas shoot, or heart failure. Immedi te Cause (Final disease i condition resulting in death) **Physician** Charl /Medical Due to or as a consequence of): Examiner cause thatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4 cathy Due to (or as a consequence of) Examiner or Attending Physiclan; The law requires that the death certificate be executed the burial-transit and A Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 donknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 Ho 1 4 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 PNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a. Certifier 1 EcrtifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3894

Registrar

State

CITH

31. Date filed (Month, Day, Year)

1201020

MEMORIAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

MICSON

DEC 05

Michelle Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 7:00 AM enise December 2008 /Medical 4b. City, Town, or Location of Beautiful Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of British Control of 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA Elerman 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🖫 F Maryjand 212-02-435 26 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "hatural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tre Medical Evannirer must be rediffed at once. 1 Nes 2 No Funeral Director Ka Iti more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ierman 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ Yo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Blac Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) emarketer Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4154 mother MD 21206 Eierman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 121 Baltimore, of Faith 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Howeli Funeral 3331 Balto. MD Brehms -n. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SUSTEM LUMPHOMA NERWOULS CENTRAL **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, 🎏 burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 H Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by - A Courked IMMUNE. MNDRGHE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 2 🗆 No 1 ☐ Yes t □Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK! 5601 LOCH RAVEN OSPHARE bWD 32 Registrar's Signature State 2008 Registrar

		-	For State Registrar	,	Cer	tificate of l	Death	Reg	g. No.	000,0		
Dh			1. Decedent's Name (First, Middle, Last)					Date of Death     Month	Day Year	3. Time of Death		
	ysicia Vedic	_	Nancy Roberta Joyne	r				November 2	20, 2008	2:00 A M		
Ex	amin	er	4a. Facility Name (If not institution, give str			4b. City, Town, or Chevel	Location of Death		4c. County of Death  Prince Georges			
Fun	oral	1.5	Prince Georges' Hospita  5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth				
Dire	4		579–54–2211	^{M 2} ⅓ ^F 70	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 10/10/193	1938 Washington, D.C.			
pu ,			Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Loc	cation				10d. Inside City Limits		
farylan show	ed at	or	MD PG			Heights				1 X Yes 2 □ No		
the N	notifi	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?		
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r deat	ar mu	Funeral	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	3. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White			
72 hours after death with the Maryland ratural", or items 23a or 28a-f show	amin	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	l∐Yes 2⊑ <b>x</b> No	Specify:		Specify: Bla	ack		
2 hour	cal E		15. Decedent's Educa	ation	16a. Deced	lent's Usual Occup	ation	. 1	6b. Kind of Business/			
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filed within Hygiene.	t, the	Co	12th		Analyst Supervisor				Federal Gove	ment		
be fi	even	Be	17. Father's Name (First, Middle, Last)  Arthur B. Wells				Virginia	e (First, Middle, M. Ragland	aiden Surname)			
should and Men	matic	ဥ	19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailin	a Address (Street			City or Town, State, 2	Zip Code)		
and 2 s ealth ar n 27 is	r trau		Maxine Joyner-Armstead						ol Heights, I			
Pages 1 a lent of Hearn tit if item	rothe		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. Pla	ace of Dispo: emetery, cren	sition (Name of natory or other plac			0c. Location - City or	Town, State		
Pag ment	ury o		4 ☐ Donation 5 ☐ Other (Specify)	ALL		Vational Ce				ington, Virginia		
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than	any in		21. Signature of Funeral Service Licensee	Reman	22 4 ^t	Name and Addres	ss of Facility Free	men Funera Hills. Mer	l Services ryland 2074	8		
			23a. Part 1. Enter the disease, or complic shock, of heart failure. List only one	tions that caused the death cause on each line.						Approximate Interval Between		
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/Med Exam	_		resulting in death)	Due to for as a consequ	ence of	1 10 10 0-	hat			1.100 60		
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or Atte	n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ri State)	ural Route Number,		
pltal o	filled in		29a. Certifier 1 Certifying Physi	cian: To the best of my know	viedae deatl	h occurred at the ti	me date and place	and due to the co	uso(s) and manner of	o stated		
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica	completely filled in by the funeral director, page	edical		er: On the basis of examinat and manner stated.								
To the within To the	comp	Me	29b. Signature and title of certifier	0 + 1	^	29c. Licens						
			104	andags m			4720		11-20-08			
-	$ \varphi $		30. Name and address of person who cor				IZNIDER		L'S TAGE W	14)		
etx .	- 01	•	31. Date filed (Month, Day, Year)	Wen Koad,  32 Registrar's Signat		ev Ly,	MD 20	182				
Re	Sta egistr		DEC 0 5 2008	100	. An	USE!						

1 - For State Registrar

Certificate of Death

Reg. No.

3	3	3	1
	-	-	

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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Registrar

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31. Date filed (Month, Day, Year)

DEC 0 5 2008

n	Sharon Anne Johnson									Debattber 01 pay 2008 Year 3:100 P M						
al er	4a. Facility Name (		n, give street and nu	ımber)					r Location ver Hi			4		of Death		
	5. Social Security N 213–76–371	15	6. Sex 1 □ M 2√2 F	7. Ag	e (In yrs. last 49	birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 04/06/1	h v, <u>Ye</u> a <b>9</b> 59	r)	9. Birthp Cour Mary	lace (State or Foreign try) Land	
ctor	Usual Residence o  10a. State  MD	10b. County	PG		10c. City, To	y, Town or Location  Landover Hills						10d. Inside City Lin 1ழ⁄es 2 □				
Dire	10e. Street and Nu					-	10f. Ziş					10g. Citizen of What Country?				
era		oktord D				140.1	20784				USA					
by Fun	<ul><li>11. Marital Status</li><li>1 ☐ Never Marr</li><li>3 ☐ Widowed</li></ul>		ied 12. Was Dec Armed F 1 □ Yes If Yes, G Year or I	orces? 2 👿 N ive		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2X No Specify:						14. Race - American Indian, Black, White, etc.  Specify: Black				
Be Completed by Funeral Director	Elementary/Seco		t's Education st grade completed) College (	1-4or 5	+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Customer Service Manager					16b.		usiness/Ind	dustry		
ပ္ပိ	12th 17. Father's Name	(First. Middle.	Last)		'	JUSTO	mer se	rviœ			e (First, Middle,	Maide		ivate		
To Be	Joseph As	, ,	•								Thomas	maroc	,,, ournar	,		
	19a. Informant's Name/Relationship (Type. Print)  Sharronda Johnson – Daughter  19b. Mailing Address (Street and Number or Rural Route Num 2403 Marbury Drive; District Height											,	, ,	Code)		
	20a. Method of Dis 1 ☑ Burial 2 4 ☐ Donation		cemetery, crematory or other place) commonly Memorial Park 12/06/2					Date 20c. Location - City or Town, State 5/2008 Landover, Maryland								
	21. Signature of Fu	uneral Service	Licensee	a	n						emen Fune Hills, M					
	ship, or hea Immediate Cause disease or condition resulting in death)	art failure. List (Final on		each lir	ne.	eior		-	ig, such as		or respiratory ar		atic		Approximate Interval Between Onset and Death	
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):															
ysician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 ∫ 9 □ Unknown	months?		birth nant at	of pregnancy 2 □ Fetal deat t time of deatl		] Ectopic p ] Other (sp							te of delive	ory Day Year	
d by Pr	Part II. Other signit	ficant condition	ons contributing to c	eath bu	ut not resulting	g in the un	nderlying o	ause give	en in Part I				use cont		e cause of death?	
Complete					<del>-</del>						24a. Was a autop perfor 1 ☐ Yes	sy		prior to coi death?	osy findings available npletion of cause of	
Be	25. Was case refer examiner?		Hospital:					Ĩ Out-		of Deat	h (Check only o	10)				
9	1 ☐ Yes 2 ☐ 27. Manner of Deat		28a. Date	Inpatie of Inju		Outpatien  Time of			4 🗆 NI	ursing Ho	ome 5 Resid				"	
1   Yes   2   No							ć? [™] Yes 2□	No					Route Number,			
Cert	4 ☐ Homicide  29a. Certifier			ing, etc	:. (Specify)				no data a	nd place	City or Tow	n, Sta	te)			
edica	(Check only one)	2 Medical	Examiner: On the tand mar	pasis of	f examination	and/or inv	estigation	n, in my o	pinion, dea	ath occur	red at the time,	date a	nd place,	anner as s and due to	the cause(s)	
ž	29b. Signature and	title of certifier		PH	MSICI	47	290		e number 5359	0				d (Month, i	Day, Year) - 3, 2008	
	30. Name and addr	ress of person	who completed cau			a) (Type, F	Print)	622 BB			LOADWA	- 7	7.17/			

Agast )

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month Day 2, 3. Time of Death **Physician** 2008 12:22 PM December Robert R. Kern, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Ellicott City 3710 St. Johns Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 😡 M 2 🗆 F Yrs. Director 81 212-20-8580 6, 1926 Maryland Dec. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show r than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Director Ellicott City Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code . 23a Completed by Funeral 21042 USA 3710 St. Johns Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Mayes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than' Irry or other traumatic event, Irra Ma Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Foreman Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Dash Frank Kern 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trainonce. 3710 St. Johns Lane; Ellicott City, MD 21042 Betty Kern Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/6/2008 New Cathedral 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service License 1630 Edmondson Avenue; Catonsville, MD 21228 1901490 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** +45 /Medical Due to (or as a consequence of): **Examiner** terios Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy cate has been signed by the atterpage 2 should be detached for Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ITTICLENG contension 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an autopsy 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only only 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Describe how injury occurred 5 Pending investigation 2 □ No

Physician: The law requires that the death certificate be executed Box 68760, P.0. of Vital Records, I or Attending P after death. Director: After t Division the completely filled in by

e Hospital of 24 hours a e Funeral C

within 2

Baltimore, Maryland 21215-0036

1 Natural Accident

6 ☐ Could not be 3 Suicide 4 Homicide

29a. Certifier

1 □Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and title of certifier

DEC 05

N.Ch.-1-15t. Site 600 Bilta mul 21294

30. Name and address of person who completed cause of Path (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-08954 State of Maryland / Department of Health and Mental Hygiene Earnestine Kornegay 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day November 28, 2008 1856 hrs Famestine Kornegay **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Suitland 3511 Silver Park Drive, #303 8, Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (in yrs. last birthday) **Funeral** Months Day Hours Min Director Country) Maryland 12/28/1945 577-60-9166 M 2X F 62 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No or items 23a or 28a-f show must be notified at once Suitland MD PG Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 3511 Silver Park Drive #303 20746 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Was Decedent Ever in U.S. lother than "natural", or items the Medical Examiner must be White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No Specify: Black Yes, Give Year Yes 2 X No specify: Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Imore, MD 21215-0036
Pages 1 and 2 should be filed within 72
nent of Health and Mental Hygiene. is marked other than Federal Government Cogniter Specialist 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Reavis Be George Konnegay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 35 Florida Avenue, N. E. #A Washington, D.C. 20002 Karen S. Kornegay - Daughter it: If item 27 is other training 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Itimore, crematory or other place) Removal from State Burial 2 X Cremation 3 12/08/2008 Beltsville, MD Chesapeake Crematory ment tant: Donation 5 Other Specify 22. Name and Address of Facility Freeman Funeral Services permit. at re of Funeral Service Ligenses 4594 Beech Road: Temple Hills, Maryland 20748 applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or c Physician Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical 23a, 27, per ME ,g887 1/14/09 TT X UNPENDED attending physician for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months Pregnant at time of death Other (Specify) signed by the atto I be detached for Yes 2 ✔ No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. δ Yes 2 ✔ No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? No 1 V Yes 2 No Yes 2 certificate To the Hospital or Attending Physician: 'within 24 hours after death. 26.Place of Death (Check only one 25. Was case referred to medical Be examiner? Other₄ Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient this 1 Yes ٩ 28c. Injury at Work? 28d. Describe how injury occurred After Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Injury 27 Certification: Natural 1 Yes 2 No Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)

10/2 pend State

OCME 2006

0 Registra DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Margarita Korell MD.

31. Date filed (Month, Day, Year)

anto

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

November 29, 2008

08-09059	
James Keener	

ames Keener		State of Maryland / Department of Health and Mental Hygiene  For State Certificate of Death  Reg. Reg.	No. 2008 3884
Physician Medical Examine	.,,	Decedent's Name (First, Middle,Last)  James A. Keener, Jr.  2. Date of Death Month December 2	3. Time of Death 2, 2008 0103 hrs
	!	Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  St. Agnes Hospital  Baltimore	4c. County of Death N/A
Funeral Director	2	212-82-3569 1X M 2 F 59 Yrs. Months Days Hours Min. May 20	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Ohio
and show any nee.	10a	ual Residence of Decedent a. State 10b. County 10c. City, Town or Location  Maryland Baltimore Co. Baltimore Co.	10d. Inside City Limits 1 Yes 2 X No
with the Maryland s 23a or 28a-f sho	<u> </u>	e. Street and Number 10f. Zip Code 10g  549 47th Street 21224  Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	Citizen of What Country?  United States  14. Race - American Indian, Black,
\$ £ 5	aun a 3	X Never Married   2   Married   Armed Forces?   If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   Widowed   4   Divorced   Divorced   1   Yes   2   No   specify:   1   Yes   2   X   No   specify:	White, etc.  Specify: White  6b. Kind of Business/Industry
5-0036 led within 72 hours a tygiene.  Tygiene than "natura" the Medical Examin	mpleted	Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  Dependant	N/A
1215- Id be filed Mental Hyg Mental Hyg event, the	e	James A. Keener, Sr.  a. Informant's Name/Relationship (Type, Print)  18.Mother's Name (First, Middle, Marker's Name (First, Middle, Marker's Name)  Betty M. Gand	lee
10re, MD 213 ages I and 2 should be to Health and Men i: If item 27 is mar other traumatic eve		a. Method of Disposition  Z Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	e, Maryland 21224 20c. Location - City or Town, State
Baltimore, permit. Pages 1 at Department of Her Important: If ite injury or other tr	4 21.	Donation 51 Other Specify: Oak Lawn Cemetery 12/5/2008  Singure Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk.	Baltimore, Maryland Dundalk, Inc. Maryland 21222
Physician /Medical xaminer	Imr	a. Fart I. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arresfailure. List only one cause on each line.  mediate Cause (Final disease condition resulting in death)  Due to (or as a consequence of):	
	Sec	equentially list conditions, any, leading to immediate use. Enter Underlying Cause	
50, te be executed by sysician and be burial - transit	eve	isease or injury that initiated ents resulting in death) Last Due to (or as a consequence of):	
Sox 68760, death certificate be exertificate be exertificate for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for use as the burial for u	IF F 23b.	UNPENDED  AMENDED  23c. If yes, outcome of pregnancy  Was decedent pregnant in the past 12 months?  AMENDED  23c. If yes, outcome of pregnancy  Live birth  2 Fetal death  3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
that the death of the by the attendetached for us	Par	Yes 2 No 9 Unknown   4 Pregnant at time of death 5 Other (Specify)  Tt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobal	acco use contribute to the cause of death?
cords, F law requires has been sign	Completed by	Seizure Disorder  1Yes  24a. Was an autopsy perform 1 ✓ Yes 2	prior to completion of cause of death?
	25.	. Was case referred to medical 26.Place of Death (Check only one)	No 1 Yes 2 No
of Vit	27	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA Other Nursing Home 5 R  Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe ho	esidence 6 Other:
ttendir feath.	2 ation:	✓ Natural 5 Pending Accident Investigation  (Month, Day, Year)  1 Yes 2 No	
Divisior Hospital or Attend 24 hours after death Funeral Director: tely filled in by the	Certification:	Suicide Could not be determined (Specify)	reet and Number or Rural Route Number, City te)
	one (Ch	and manner stated.	nd place, and due to the cause(s)
		Carcle Hellda O.C.M.E.	29d. Date signed (Month, Day, Year)  December 2, 2008
4		Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat Registra	~~	Date filed (Month, Day, Year)  32. Registrar's Signature	
DHMH 17 Rev 1/200	1	OCME ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Andrew Kunkowski November 29,2008 10:13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Ctr. Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □XM 2 □ F Director 212-20-4236 83 June 27,1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at Director Maryland Baltimore Dunda1k 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 7707 Eastdale Road "natural", or items 23a 21224 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after XXYes 2 No li Yes, Give Year or Dates: 1943-46 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, Itel Once. Manufacturing Western Electric Co. 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matilda Joseph Kunkowski Lewinski 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7707 Eastdale Road Baltimore, Maryland 21224 Mrs. Virginia M. Kunkowski 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 12/3/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland om 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cartonascular Athenselevere disease or condition resulting in death) Many Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, iner cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a gunsponence offi Physician/Medical Exam burial-tran resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, physician the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown à s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown cate has b page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 ☐ No 2 (XNo or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation ours after death.
neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Kim, The 31. Date filed (Month, Day,

Hopkins Hospital 600 North Wolfe Street, Baltimore 32. Registrar's Signature

Medica!

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julis

DOCCO

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RES-000

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** William Knight November 5:50 AM 29 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1X M 2 □ F Dec. 26,1960 Director 220-72-4240 47 Maryland Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Baltimore City tx XYes 2 □ No Director Maryland N/A 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21224 United States 500 South Newkirk Street Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. ģ Specify. 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Cabinetry 12 Years Cabinetmaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth M. Miller Milton J. Knight 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1915 Dundalk Avenue Dundalk, Maryland 21222 Mr. Milton J. Knight (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 12/3/2008 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk, Maryland 21222 21. Signature of Emeral Service who 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure
Due to (or as a consequence of): **Physician** 10 hours resulting in death) /Medical Examiner Years Due to (o's a consequence of) Concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy lor in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9□Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed? certificate 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) 32 Registrar's S

2008

ROBERT A. MEGUID

DEC 05

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, MPH.

32 Registrar's Signature

fore

RES-000

600 N. WOLFE ST, BALTIMORE MD 21287

November 29,2008

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#22perFH, G886, 12/5708, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1^{Month}  $3^{\text{Day}}$ 2008 Clara Lane 6:45a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 911 N. Carey Street If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2√2 F Director 87 212**-**22**-**3271 01 02 NC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar nust be notified at 1 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 911 North Carey Street 21217 Funeral U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or If Yes, Give Year or Dates: Black 1 ☐ Yes 2 ☑ No Specify: \$ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Domestic Engineer na Private Families 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Talmadge Obie Evie Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Smith-Daughter 5206 Elmer Ave, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 12/9/08 Woodlawn, Md 22. Name and Address of Facility West 4300 Wabash 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic breast cancer disease or condition resulting in death) Merci /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Hourt failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Denentia 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, detached signed be det director, page 2 should has been this certificate filled in by the funeral After death. 24 hours after death • Funeral Director: To the I within 2

within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

Robert Davidson MD 301 St. Pu-1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DOO 65249

Place Suine 801

December. 3, 2008

Rulhman, MD 21702

08-08916 Raymond Lee Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aymond Lee	1- F	St or State	ate of Marylan		rtment of tificate of		and N	Vlenta	ıl Hygie	ene Reg.	No. 2	00	8 3334	
Physician/	Req 1. [	istrar Decedent's Name (First, Middl	e,Last)							ate of Death			3. Time of Death	
ledical Examine		aymond		Ν		Lee				onth ovember 2	7, 2008		1908 hrs	
	4a.	Facility Name (if not institution 4119 Woodhaven Ave		per)	4	tb. City, Tov Baltimo		cation of I			4c. County o			
Funeral	5. 8	Social Security Number	6. Sex 7.	Age (In yrs. la	st birthday)	If Under	_	If Under 2 Hours	24Hrs. 8. I Min.	Date of Birth	MM/DD/YYYY	9. Birth Foreign	place (State or	
Director	2	215-28-5043	1 X M 2 F	77	Yrs		Days	Tiours	1	1 01	31	Cour	ntry) MD	
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or items 23	2	Never Married 2 N	1 Yes	2X No	j	Yes 2X					Specify:	R1	ack	
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2 hour "nate		Elementary/Secondary (0-12)			during m	nost of worki	ng life. D	O NOT u	se retired)					
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15-0036 filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygene. ad other than "natural", or items 23a or 28a-f she is, the Medical Examiner must be notified at once of Commission by Fumeral Director		. Father's Name (First, Middle	e, Last)								aiden Surname	*)		
21215-0036 sold be filed within 7 Mental Hygiene, marked other than it event, the Medica	Robert Lee Gertrude Nicho  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Num						Route Numb	ber, City or Town, State, Zip Code)						
and sho		Irvin Lee-B			4119	Woo	dhav	ven	Ave,		imore			
~ 구성 등 표정	20	a. Method of Disposition	O Demond from		Place of Dispor		of ceme	etery,	Da	te	20c. Location	- City or 1	Fown, State	
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Baltimore, permit. Pages 1 at Department of He. Important: If ite injury or other tr		. Signature of Euneral Service		1	Ma Ma	Name and A	ddress o	f Facility Wes	t					
	1	Mabash Ave, Baltimore, Md 21215  Representations the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval												
Physician Medical	e.	failure. List only one cause on each line.												
aminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												
		Sequentially list conditions,								_				
led Insit	if c	if any, leading to immediate cause. Enter Underlying Cause c.  Due to (or as a consequence of):												
ait d	e (I	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):												
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50, te be e ysiciai	<u> </u>	UNPENDED FEMALE:	23c. If yes, o								23d. Date of	of delivery		
Box 68760, he death certificate be the attending physici hed for use as the buri	Puysician/w	bb. Was decedent pregnant in past 12 months?	the 1 Live bi	rth	2 F	etal death	3	Ectopic	pregnancy		Month	С	Day Year	
OX 6	)     1	Yes 2 No 9 U		ant at time of d	eath 5 C	other (Spec	ify)							
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- S	2	Chronic obstructive pulmonary disease (COPD)							1 Yes 2 No 3 Probably 4 ✔ Unknow  24a. Was an autopsy  24b. Were autopsy findings availa prior to completion of cause					
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Sion Attending a death ector: // by the fi	cati	2 Accident In	vestigation 28e Place	e of Injury - At	home, farm, str	reet, factory,						ber or Ru	ural Route Number, City	
Division of Nital or Attending Ph. ours after death.	[등		ould not be stermined (Specify)							or Town, S	tate)			
DIVI	ح ا ت	9a. Certifier	Physician: To the bes	t of my knowle	dge, death occ	curred at the	time, dat	te and pla	ace, and du	e to the caus	e(s) and mann	er as stat	red.	
To the Hos within 24 h		(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier.  29c. License number  29d. Date signed (Month, Day, Year)												
	ΣZ	29b. Signature and title of cert	ifier	1		290						,		
		30. Name and address of person who completed cause of death (Item 23a)								December 4, 2008				
<b>V</b>	3	<ol> <li>Name and address of pers Zabiullah Ali, M.D.</li> </ol>	on who completed £aus Assistant Medic			enn Stree	t, Balti	more, l	MD 2120	)1				
Sta	te 3	31. Date filed (Month, Day, Yea	ar) 32	egistrar's Signa										
Registr		DEC 0		die 1	F 199	3452								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2249PM 12 2008 Julie Anna Lemmon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Square Hospital CenTer Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 22, 9. Birthplace (State or Foreign Country) West Virginia Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🛛 F 50 1958 Director 212-80-2258 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Madical Evaminar must be notified at 1 □Yes 2X No Director Baltimore Middle River Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 760 Lannerton 21220 S. A. Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item Many Injury or other traumatic event, Item Many Injury or other traumatic event, Elementary/Secondary (0-12) College (1-4or 5+) 11 Nursing Assistant Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William Tichenor Cora Sue Pigott 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 Altenburg (Mother) Sue 618 Bowleys Quarters Road Middle River, Maryland 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/4 2008 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hepatic FaiLure **Physician** Acute /Medical Due to (or as a consequence of): Examiner and Stage Liver
Due to (ur as a consequence of): disease Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed cirrhosis LIVER signed by the attending physician and the detached for use as the burial-tran Due to (or as a consequence of): O. Box 68760, Physician/Medical Hepatitis as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Hepato 1 🗌 Yes 2 → No 3 Probably 4 Unknown Syndrone Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No certificate 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After thi funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESOGOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN Square DR 9000 Balto md Pierre valeus 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 05 Registrar

08-08715 Terri Louise Leonard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 38350

		For State Certificate of Dea	ath			Reg. I	No.	Base of the			
Physician/	1.	Registrar 1. Decedent's Name (First, Middle,Last)  Mont						ear	3. Time of Death 0444 hrs		
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(	4	a. Facility Name (if not institution, give street and number) 4006 28th Avenue, Apartment# 203  Ten	Prince George's								
Funeral Director	- 1	, Social Security Namber	nder 1 Year nths Days	If Under 24 Hours	Min	ate of Birth (N			place (State or DC Washington		
any	_	Isual Residence of Decedent  Oa. State 10b. County 10c. City, Town or Location							10d. Inside City Limits		
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Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and Important: If iten 27 is ninjury or other traumatic.		1 Burial 2 X Cremation 3 Removal norm state Chesapeake Crem	natory	١.	11/29/2				Maryland		
taltii rmit. epartim inports jury o		22. Name and Address of FacilityFreeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748									
	1	23a. Fakt I. Enter the disease, or complications that caused the death. Do not enter the more failure. List only one cause on each line. <b>Diabetic Ketoacidos</b>	de of dying, s	such as card	diac or resp	iratory arres	shock, or	heart	Approximate Interval		
Physician 'Madical		failure. List only one cause on each line. Diabetic Ketoacidos Cardiovascular Dise	is Co ease	mplic	ating	Нуре	rtens	ive	Between Onset and Death		
aminer		or condition resulting in death)  Due to (or as a consequence of):									
h (		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	<u>[</u>	cause. Enter Underlying Cause (Disease or injury that initiated									
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.											
760, reate be executed physician and the burial - transit	Medical	x UNPENDED 23a,27 per me g886 12-20-08 vt									
760, ficate be g physic the burn		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	pregnancy		23d. Date Month	e of deliver					
Box 687  • death certifithe attending ed for use as t	<u> </u>	past 12 months?  4 Pregnant at time of death 5 Other (9)									
BO he deat the deat he deat for	Physician	1 Yes 2 No 9 ✔ Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the under	L.	23e. Did tobacco use contribute to the cause of death?							
ires that the designed by the	≦	Fart II. Other Significant Conditions		1 Yes 2 No 3 Probably 4 Vunknown							
require	Completed		(4)	24a. Was an autopsy findings autopsy prior to completion of ca							
tal Records, cian: The law requir certificate has been sector, page 2 should	ᇤ					perform 1 Ves 2	red?	death?	es 2 No		
an: Ti	ပ္ကို - မ္က	25. Was case referred to medical	26.Place	of Death (C	Check only						
Division of Vital Records, tat or Attending Physician: The law require and reduced the state death.  In Director: After this certificate has been sited in by the funeral director, page 2 should be a state of the funeral director.	인	examiner?  1 Ves 2 No  1 Pospital: 1 Inpatient 2 ER/Outpatient 3  27 Manner of Death 28a Date of Injury 28b. Time of Injury	DOA Inju	Other ₄	Nursing Ho	me 5 F	tesidence		r: Scene		
n of		27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury	-	res 2 1	i		·····,···,				
risio r Atter er deat irector irby th	licat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fac	. 28f.	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Division of Vital Rec pital or Attending Physician: The ours after death. Terral Director: After this certificate! filled in by the funeral director, page	Certification:										
8 4 5 7		29a. Certifier (Check only one) 2	at the time, da in my opinion	ate and plac i, death occi	e, and due urred at the	to the cause time, date a	(s) and mai nd place, a	nner as sta nd due to t	ted. he cause(s)		
To the within To the comp	Medical	and manner stated.  29b. Signature and title of certifier	29c. Licens						onth, Day, Year)		
		16 0 14 Big - 1	November 21, 2008								
30. Name and address of person who completed days in death (Itani 23a)											
V,		The odd of the talling, and	Penn St	reet, Balt	umore, N	21201 עוני	_		<del></del>		
Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 5 2008									

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Year **Physician** Labrene Lambrow 1:00 A M 3, December 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Towson Gilchrist Hospice Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 12,1922 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 069-16-6436 1 □ M 2 🕏 F 86 Director New Jersey Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, if a Nobical Examin or must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Director Dundalk 1 ☐ Yes 2X No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 Liberty Parkway 21222 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2 ☐No 14. Race - American Indian. 1 ☐ Yes 2x If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No þ Specify: Specify. 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thespina Sotoreos Gus Sotoreos ဂ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000 Liberty Parkway Dundalk, Maryland 21222 Stephanie Lambrow (Daughter) Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 12/5/2008 /Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature neral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician OUANIAN C ANCER metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to many cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) 9 Unknown 9 Unknown cate has been signed page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 2 🗆 No 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à determined 4 Homicide filled in 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 3, 2008 5205 116) 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Climbes St. falto. Md Zizox (12 6701 hono 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 Charles Andrew Linz 4:55 AM December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Nursing Center Towson Baltimore Co. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 26, 1927 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In vrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Director 81 214-22-7937 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f show the Medical Evanular must be notified at Director 1 ☐ Yes 2\ StNo Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21220 United States death v 30 Tearose Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ∰Yes 2 No
If Yes, Give
Year or Dates: WWII 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: <u>6</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) General Motors Corp. 10 Years Electrician 27 is marked other er traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Anna Teljohn Conrad Linz ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Tearose Drive Middle River, MD Mrs. Nancy M. Linz (Wife) permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest V.A. Cem. 12/4/2008 Owings Mills, MD 4 Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final coronary BUSTASC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perform 1 □ Yes 1 ☐ Yes 2 □No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) W. Spirit 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🖔

2003

Baltimore, Maryland 21215-0036

Attending Physician: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

investigation

6 Could not be determined

5 0

2008

29c. License number

🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

CHAMES wo 701 Charles N 82. Registrar's Signature Year) 31. Date filed (Month, Day,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

2 Accident

4 Homicide

(Check only

29b. Signature and title of certifier

3 Suicide

29a. Certifier

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**  $A^{M}$ Benjamin Harry Lebo December 1, 2008 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F Months Days Hours Min. 219-16-4017 Director 12-16-1915 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examination retired at 1 ☑ Yes 2 ☐ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 7100 Old Harford Road Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 🗶 No Specify: þ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jake Lebo 2 Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Mr. Michael Bocklage - Grandson 2609 Grey Manor Terrace Baltimore, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 12/04/2008 Baltimore, Maryland 21. Signature of Fungral Servi All censes 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin disease or condition resulting in death) **Physician** 5 yan /Medical Due to (or as a consequence of): Examiner ioheral insculor disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4 ☐ Pregnant at time of death 5 Other (specify) P.O. s been signed by the should be detached 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate his completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 12/1/08 Wicton dlial 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tusen, MD 21201 Allwon Habes N. Charles St. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State nFC 0 5 Registrar

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death ecedent's Name (First, Middle, Last) Month Day 56DM **Physician** 26 NOV. ලපු /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and numb Examiner (timor VA Medica More If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Virginia Days Hours 12 M 2 ☐ F 64 228-50-2964 November 5,1944 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Virginia Clarke Berryville 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11430 Harry Byrd Highway 22611 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Allied Foces: 1 [⊉Yes 2 □ No If Yes, Give 1965–1971 Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🛂 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Landscaping Lawn Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Leonard McNealy Dorothy Mae Payton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lorraine L. McNealy/Wife 11430 Harry Byrd Highway, Berryville, VA 22611 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Berryville, VA Green Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Enders and Sirley Funeral Home Sonature o Funeral Service Licensee P.O. Box 106, Berryville, VA 22611 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 2082 Physician disease or condition resulting in death) /Medical Due to (or as a contequence of): **Examiner** ungerma Sequentially list conditions, if any, bearing to instruction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tyes 2 No 3 Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 🗀 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🖲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 🖀 Natural 1 ☐ Yes 2 ☐ No 2 Accident

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

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Items 23a or 28a-f sh ner must be notified

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be n

Baltimore, Maryland 21215-0036

attending physician ed by the a nis certificate has been signed by director, page 2 should be detacl this After s after dea.

within 24 hours a

To the Funeral C

completely filled

State Registrar

funeral

filled in by

29c. License number 71105 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print) 30. Name and essi

6 Could not be determined

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certific

10 N. Creene St. Balkimore

1 (a) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008 05

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2, 2008 6:25 AMM Albert Milke, Jr. December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Autumn Assisted Living Hagerstown Washington Birthplace (State or Foreign Country) Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 XM 2 □ F Months Days Hours Min 92 July 10, 1916 Maryland Director 213-07-9415 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f sho Completed by Funeral Director 1 ☐ Yes 2 XNo Clear Spring Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21722 S. U. P.O. Box 137 Α. 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1944 1 ☐Yes 2 XNo Specify: Specify: 3 ◯Widowed 4 □ Divorced White 1946 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 / Operator Hardware Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H Item 27 is marked oth other traumatic even Be Albert Milke, Sr. Marie Elizabeth Bahlke ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 137 Clear Spring, Maryland 21722 <u>Barbara Jean Main (Daughter)</u> item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 12/5 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 0 23a. Part 1. Enter the disease, or application— hat caulled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End SLEL Dementos disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by District Mallitin 1 Tyes 2 No 3 Probably 4 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 (Definer (Specify) ASSISTED Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2⊉No Medical Certification: To the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANaturat 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

Registrar

Baltimore, Maryland

P.O.

of Vital Records,

Division

31. Date filed (Month, Day, Year)

wanteno

DATTA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

05

MO

340 MILL ST

D18019

MALERITOWN

DEC 2, 2008

MD21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland /PSEPHYS 6886 122115 408 Wental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:00 P M FLORENCE **MYERS** NOVEMBER 29, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FOREST HILL HEALTH AND REHABILITATION FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Feb. 26,1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 X F 92 Director 215-10-7918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at a or 28a-f sh 1 ☐Yes 2 X No Director Maryland Harford Bel Air the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "nature" any injury or other traumating enterminents. 21015 USA 2351 Pennington Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: White 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilson Matthews Lioba Clara Dotterweich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2351 Pennington Road; Bel Air, Maryland 21015 Gail Gitschier Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 12/2/2008 Woodlawn, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service 1630 Edmondson Avenue; Catonsville 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes \2 ☐ No 24a. Was an autopsy performe 2□No certificate 2 No 1☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes A No Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation ours after death. nerai Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerail 29a. Certifier 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day

DAVID DUNN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615

W. MACPHAIL ROAD

32. Registrar's Signature

29c. License number

23552

BEL AIR, MD.

29d. Date signed (Month, Day, Year)

21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3885 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 2008 **Physician**  $03^{\circ}$ 06:00 рм Philip J. Maurer. Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3917 Parkside Drive N/A Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**M** 2□F 216-28-6333 -Maryland 76 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show be notified at 28a-f show 1 X Yes 2 □ No MD N/A Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 "natural", or items 23a odical Examiner must b 39177Parkside Drive U.S.A. Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1952-54 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White ğ 3 X Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) Truck Driver Oil Burner Supply d 2 should be filed w th and Mental Hygier 7 is marked other tt other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Maurer Alice Herold ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traum Dorothy Trish, Daughter 3915 Parkside Dr., Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/09/2008 | Baltimore, Maryland Most Holy Redeemer 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licenses Mejorana 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unionly in Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine be executed burial-transi and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig , page 2 should b Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No 3□ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

Box 68760. P.0. Division or Vital Records, To the Hospital or Attendia within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MTH POINT aD 9600 Kumatt 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 0 5 2008

1 6363

29d. Date signed (Month, Day, Year)

State

Registrar

(Check only one)

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death **Physician** /Medical Facility Name (If not institution, City, Town, or Location of Death County of Death give street and number. **Examiner** Atmore TO MOVE Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number **Funeral** Min 1 ☐ M 2 🂢 F 87 6, 1920 Dec Massachusetts Director 016-14-7384 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ? Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Mexical Experiment must be recitled at Director 1 □Yes 2 → No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 USA 320 N. Ridge Road #319 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: White Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) 12 Hygiene. College (1-4or 5+) secretary lega1 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item Z7 Is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Clark Christine McInnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) April Richstein/daughter 13129 Clifton Road Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Baltimore. MD 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on Physician: The law requires that the death certificate be executed -transit and Due to (or as a consequence of) attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for ı∏Yes 2 No P.0. 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has After this certificate 2. No 1 Yes funeral director, 25. Was case referred to medical examiner? Dition 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 D No Other: 4 Nursing Home 5 Residence rospie 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify) Certification: To 27. Manner of Death Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending Injury within 24 hours after death.

To the Funeral Director: A:
completely filled in by the fu 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 690° WANG 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DEC 0 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 7:10 A M December Carvel E. Monks, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Belair Harford 8. Date of Birth (Month, Day., Ye. March 24, 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. , ^{Year)}1931 Birthplace (State or Foreign Country) **Funeral** 77 Director 214-26-3734 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No MD Baltimore Belair 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1840 Prindle Dr. 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 □Yes 2 🗓 No Specify: ģ Health and Mental Hygiene. 3 ☑ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Delivery Agent Radebaugh/Floral 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carvel E. Monks, Sr. Naomi Brooks မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2238 Gelding Way Michele Barco/Daughter Belair, MD 21015 permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other: 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State December 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2, 2008 Glen Burnie, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Signature of Fune Michael J. Flag1e 23a. Part 1. Enter the disease, or complications that caused the distribution and the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as onsequence of) been signed by the attending physician and should be detached for use as the burial-trathat initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9 Unknown Part II. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Mype, Print) 4+1 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner 1050. to DOUTO Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year) 10/12/1945 **Funeral** Days 1 X M 2 □ F Months Hours Min. 63 212 44 3571 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 28a-f show injury or other traumatic event, the Medical Examiner must be notified at N/A Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 4015 - 2nd Street 21225 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after a nent of Health and Mental Hygiene. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Surveyor Sea Coast Engineering Department of Health and Mental Hygis Important: If item 27 is marked other than any injury or other traumatic event, In once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. Manby Jr. Mildred L. Farne ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Manby / Wife 4015 -2nd Street Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/04/2008 Baltimore, Maryland Cedar Hill Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIAC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MOCANDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed anten) CORUNA127 D.SC Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe Division of Vital 2 No 1 ☐Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manne of Death 1. Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

1. Decedent's Name (First, Middle, Last)

**Physician** 

/Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

George Wilson Manby III

Reg. No.

Day

4c. County of Death

U.S.A.

Specify:

23d. Date of delivery

1 ☐ Yes

Day

24b. Were autopsy findings available prior to completion of cause of death?

Month

14. Race - American Indian.

White

November 26 2008

3. Time of Death

1:11

9. Birthplace (State or Foreign

10d. Inside City Limits

21225

Approximate Interval Between Onset and Death

Year

1 X Yes 2 □ No

Maryland

2. Date of Death

within 24 hours after death

To the Funeral Director:
completely filled in by the 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifie 29c, License number 0061435 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 3001 S. HANDVER STREET BALTIMON MI) 21005 HNDREW DUKOV. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **ORIGINAL** 

4 ☐ Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month M. 8:00 PM /Medical Facility Name (If)not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DUNDALK BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□ M 2□F 78 APRIL 13,1930 MD Director 217-26-1667 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "naturel", or Iteme 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director BEACHWOOD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3 OYSTER CT 21219 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify. þ 3 ☐ Widowed 4 ♥ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY INSURANCE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental DRIVER HIGGS MARIE GOETZINGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other treu 4211 WITERRODE WAY PERRY HALL, MD 21236 HOWARD NORRIS-SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 12/6/08 BALTIMORE, MD SACRED HEART OF JESUS 22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC 21. Signature of Funeral Service Licepsee BALTIMORE, MD 21224 6224 EASTERN AVE 23a. Part Enter the disea a, or shock, or heart failure. on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed transit Due to (or as a consequence of) -purialphysician Physician/Medical the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ŏ Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☐ hknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed certificate 1 Yes 2 D No 25. Was case referred to medical examiner? 26. Place Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Voluming Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Mann 1 Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 Accident neral Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. To the Hospitel or Attending within 24 hours a To the Funeral D completely

DEC 0 5 2008 Registrar

(Check only one)

29b. Signatura and title of certifie

of death (Item 23 1 (Type, Print)

327 Registrar's Signature

		For State Registrar  1. Decedent's Name (First, Middle, La.	st)		Ce	rtificate of	Death	2. Date of Dea	Reg. No.	JUB	3. Time of Death
Physicia: /Medica		James Paul Nelson						Month 12	Day	Year 2008	18:23 M
Examine	.a.	4a. Facility Name (If not institution, giv Good Saimari	e street and number)		2/	Baltin			4c. Cour	nty of Death	
Funeral Director		5. Social Security Number 213-66-8551  Usual Residence of Decedent		je (In yrs. i	last birthday) Yrs.	Months Days			1955	9. Birth	place (State or Foreignta) Yand
yland how at		10a. State 10b. County			y, Town or Lo					T	10d. Inside City Limits
Ba-f sl	ector	MD N/A		Bal	timore	10f. Zip Code	*				1 X Yes 2 No
ath with the 23a or 2	Funeral Director	10e. Street and Number 2901 E. Northerr		U.S.A	•						
re, Maryland 21215-0036  re, Maryland 21215-0036  s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. It health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	۾	11. Marital Status  1 □XXNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:			Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☒ No		Specify Yes or No- rto Rican, etc.)	Spec	ace - Ameridack, White,	
21215-00 21215-00 ed within 72 hor gjene. er than "natur. the Medical E	Completed	15. Decedent's Ed (Specify only highest gra	lucation ide completed) College (1-4or t	5.1)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of we ed)	orking	16b. Kind of		·
212 212 213 ed with ed with ygiene ygiene her tha	Co	Elementary/Secondary (0-12)		5+)	Road	Maintena					County
land	lo Be	17. Father's Name (First, Middle, Last, John Maynard Nels					Justine	ame (First, Middle, . e Bragg	Maiden Surn	ame)	
CON STEP STEP STEP STEP STEP STEP STEP STEP		19a. Informant's Name/Relationship ( Mrs. Justine Nels		r				Rural Route Numbe			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examione.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification)	Removal from State	20b. P		osition (Name of ematory or other pla		Date /08/2008	20c. Location Parkvi		
Balti permit. Departi Importa any Inji		21. Signature of Funeral Service Licer	ISEE C	au		2. Name and Addr 5305 Harf		Leonard . d, Baltim	J. Ruc ore, M	k, Ind D 2121	14
Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. WCM SP.  Due to (or as	nall a consequ	Ce.11	Lung		ac or respiratory arr	rest,		Approximate Interval Between Onset and Death
876( ate be hysicia the bur	edical Examiner	Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as  Due to (or as	a concey	uence ofy:						
Box eath cert attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Feta	I death 3	□Ectopic pregnanc □ Other (specify)	гу			Date of deliv Month	ery Day Year
rcords, P. (wequires that the speen signed by should be detact	2	Part II. Other significant conditions of	ontributing to death b	out not resu	ulting in the u	ınderlying cause gi	ven in Part I.	100.00			he cause of death?
The law reate has bee	Completed							24a. Was a autop: perfor	sy	o. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
or Vital Rephysician: The this certificate he all director, page	lo Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No				III JU DOA	her: 4 Nursing	eath <i>(Check only on</i> Home 5 ☐ Resid	ence 6 □C		fy)
Division or Vital Records, P.O. or Attending Physician: The law requires that the dather death.  Director: After this certificate has been signed by the tinneral director, page 2 should be detached.	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  5 Pending investigation 6 Could not bedetermined		y Year) urv - At ho	28b. Time o Injury ome, farm, str	Wa	]Yes 2□No	28d. Describe h	treet and Nur		al Route Number,
_ <u>e a s a                                 </u>	Medical Ce	29a. Certifier 1 ✓ CertifyIng Pt (Check only one) 2 ☐ Medical Example (Check only one)	ysician: To the best niner: On the basis of and manner st	of examina	wledge, deat	th occurred at the to	ime, date and plac opinion, death occ	ce, and due to the courred at the time, co	cause(s) and date and plac	manner as s e, and due t	stated. o the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier					se number		29d. Date sign		
2	ŀ	30. Name and address of person who Natallia Mercz. G	completed cause of d	death (Item	1 23a) (Type,	Print) 5	601 LOCK	RAVEN F.	31.00	-7	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 **Physician** 6:00 Broderick Crawford Nicholson, Sr. 08 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Good Samantan Baitmore Hospital N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1954 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 **X**M 2 ☐ F 53 213-60-4374 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No by Funeral Director N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1106 Ramble Wood Road, Apt. A 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes Ž No Specify: Maryland 21215-0036 Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Catering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 is marked ott Be Nicholson George Doris Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lilly Mae Nicholson - wife 1106 Ramble Wood Road, Apt. A, Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 12/03/2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Leven H. Williams ²Cremation Society of Maryland, Inc. Whi 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Severe Cardiomyopathy /Medical Due to (or as a consequence of): Examiner alcohol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last USE Due to (or as a consequence of Examiner as the burial-tran Division or Vital Records, P.O. Box 68760 Due to (or as a consequence of): attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a ld be detached for 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown anoxiz brach injury 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an tallure has performed? 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director; After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) MD 12-01-199

State Registrar

Bultmore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven

32. gistrar's Signature

Loch

DEC 0 5 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔈 📋 🥛 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dec. 2008 Anna Louise O'Laughlen 1:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug. 18 Country) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🙀 F 1910 218-34-0938 98 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner rust be notified at Director 1 ☐ Yes 2 ☐ No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. 21234 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 No Specify: white Specify: þ 3 Widowed 4 □ Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a Bakerv Manager Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin William Tawnev Elizabeth L. Krause မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Comegvs/daughter 1110 Chatterleigh Circle, Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 11 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery :12/4/08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Michae Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 ag le 23a. Part 1. Enter the disease, or complications that daused the shock, or heart failure. List only one cause on each line. leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neesco **Physician** rvm /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Duc to (or as a consequence of) Exami ending physician and use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death atter for u 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has lirector, page 2 s 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760,4 Division of Vital Records, After this certific funeral director, To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

> License number 2.5

clarles St.

Batto M12,204

Registrar

Medical

120 A ٤ 31. Date filed (Month, Day, State

29b. Signature and title of certific

32. Registrar's Signature

Bonc

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14

amend #11 Per FH G886 12/09/08 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Peterson 2:55PM Ernest 2008 DECEMBERUL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Year 1 X M 2 □ F Director 218-28-7668 26 33 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Baltimore Director tX Yes 2 □ No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 3203 St. Ambrose Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Tes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes ¾□No Specify: ģ Specify: Black 3 Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Construction 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Janie Dukes Sanders Peterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21215 3203 St. Ambrose Ave, Baltimore, Md Lillie M. Peterson-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 12/10/08 Owings Mills, Md 21. Signature of Funeral Service Licensee March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Imme late Cause (Final Physician ASPIRATION PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading I immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CEREBROVASIULAR ACCIDENT 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown VASCULAR DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No 24a. Was an autopsy performed? 1 Yes 2 □ No Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 hor To the Fune completely fi Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00065861 2 2008 M.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2717 HAMMONDS FERRY PD BALTIMORE, MD 31227 HASAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 05 2008 Registrar

Amend #30 per DVR G886 12/5/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2008 1,05 AM VGENIA 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Deg 05 inthicum the Chesa Peake PICE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 □ M -20-7196 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits GAMBRILLS 1ZYes 2□No 10f. Zip Code 10g. Citizen of What Country 2011 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗖 Ño If Yes. Give Specify. 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) onzest use w 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Walker ben Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) Columbia 114 AU ghta MADRIGAL ERR 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State NATIONE 12-18-08 4☐Donation 5 ☐ Other (Specify) urg of Funeral Service Licenses 20794 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only on Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify HUS DICE 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury 28b. Time of Injury 28d. Describe how injury occurred

**Physician** /Medical Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed and

**Physician** 

/Medical

10a. State

Director

Funeral

2

Completed

Be

ဥ

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Eventuar trust be notified at once.

Baltimore, Maryland 21215-0036

burial-trar ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical \$ Completed this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be

Division of Vital Records, P.O. Box 68760,

Certification: To

Medical

1 ☐ Yes 27. Manner of Death 1 Natural 2 Accident

29a. Certifier

3 ☐ Suicide 4 Homicide

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

5 Pending investigation 6 ☐ Could not be

and manner stated.

28e. Place f Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 □Yes 2 □No

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of deat (Item 23a) (Type, Print)

Jr., MD 1132 Annapolis Rd. Odenton, MD 21113 William Legrand Hunter,

State Registrar 31. Date filed (Month, Day, Year) DEC 05



within 24 hours a

To the Funeral L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiené UUD Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dorothy Pea1 December 2008 2350 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford 8. Date of Birth (Month, Day, Year) Nov. 12, 1932 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2√2F 76 225-46-1026 Yrs Director Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at 1 Tyes 2 □ No Directo VA Richmond 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 815 N. 35th Street or items 23a 23223 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: **Black** 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Nursing Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil trent of Health and Mental H tent: if Itam 27 is marked otl jury or other traumatic aven Alfred Leggins Mary (unavailable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnny Barton - Son 1355 Lewis Lane Havre de Grace, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: if sny injury or once. Quantico National Cem. 12-10-08 4 ☐ Donation 5 ☐ Other (Specify) Triangle, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Pierce Funeral Home 9609 Center St. Manassas, VA 20110 23a Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebral unknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) after death.

I Diractor; After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ■ Inpatient 2 □ ER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide To the Hospital within 24 hours at To the Funeral D Medicai 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 i Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12,2,2008 D0065421 Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Union Avenue, Havre de Grace, MD Christa Fistler 501 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

hysici		1 - State Registrar  1. Decedent's Name Nanilee		Last) Powell		Cel	rtificate of	Dealli	2. Date of Deat	eg. No.	3. Time of Death 0342 A M		
/Medic Examin		4a. Facility Name (/			mber)			r Location of Death		4c. County of Deat			
		Prince Geo  5. Social Security N	_	spital . Sex	7. Age (In yrs	last hirthday)	Cheverly  If Under 1 Year	•	8. Date of Birth	P.G.	thplace (State or Foreign		
ineral rector		577–42–8842 Usual Residence of	2	1□ M 2 🔀 F	92	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 05/15/19	Year) Co 16 Penn	sylvania		
w H	_	10a. State	10b. County			ity, Town or Lo					10d. Inside City Limits		
88a-f s	ecto	D.C.				Washingt	10f. Zip Code			0g. Citizen of What Co	17 Yes 2 □ No		
Sa or	Funeral Director	10e. Street and Nur 120 - 36th		N.E.			200°	19		U.S.A.	uriu y :		
as 2	nera	11. Marital Status			edent Ever in L		Was Decedent of h	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - Ame			
al", or ite	þ	1 ☐ Never Marri 3 ☐ Widowed	ied 2□ Marrie 4□ Divorced		2√2 No ve No		1 □ Yes 2 ☑ No	Specify:	nican, etc.)	Black, White	_		
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other vent, I	Be C	17. Father's Name		ast)				18. Mother's Nam		Maiden Surname)			
arked atic e	To E	Emest I	lester			_		Amie					
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maxical Evandrum count by natified at once.		19a. Informant's Na Eva J. Co	_	- Daughter				t and Number or Ru		r, City or Town, State, 2 D.C. 20019	Zip Code)		
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Importa any inju once.		21. Signature of Fu			1 DA	22	2. Name and Addre	ess of Facility Free	emen Funera	al Services aryland 2074	8		
		23a. Part 1. Enter t	he disease, or c	omplications that only one cause on g	caused the dea			ng, such as cardiac		<del></del>	Approximate Interval Between		
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s been shoul	lete								24a. Was a	n 24b. Were au	utopsy findings available		
2 CI	Completed by								autops	sy prior to med? death?	completion of cause of 2 □ No		
ate ha	BeC	25. Was case refer examiner?	rred to medical				The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		th (Check only on				
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Funeral Director: After this certificate hat lely filled in by the funeral director, page:	ical Certification: To	2 Accident 3 Suicide 4 Homicide	6 Could no determin	Physician: To the xaminer: On the b	e best of my kn	nowledge, deat nation and/or in	h occurred at the to	time, date and place opinion, death occu	, and due to the o	cause(s) and manner as late and place, and due	s stated.		
o the Funeral Director; After this certificate ha ompletely filled in by the funeral director, page :	Medical Certification: To	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	6 Could no determin	Physician: To the xaminer: On the b	e best of my kn	nowledge, deat nation and/or in	vestigation, in my	opinion, death occu	rred at the time, d	late and place, and due	h Day Year)		
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To the Funeral Director: After this certificate hat completely filled in by the funeral director, page:		2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	6 Could no determin	Physician: To the xaminer: On the band man	e best of my kn pasis of examin ner stated.	eation and/or in	vestigation, in my	opinion, death occu	rred at the time, d	iate and place, and due	h Day Year)		

State Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-09016 amend #20b PerFH G886 Certificate of Death Parrish Parker 1- For State Registrar

1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 2306 hrs November 30, 2008 a Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs, last birthday) If Under 1 Year 5. Social Security Numbe 6. Sex Foreign Country) **Funeral** Davs Hours Min Months Director 1 M 2 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Numbe 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2X No Yes Yes 2 No specify: Specify If Yes, Give Year Divorced 3 event, the Medical Examiner 16b. Kind of Business/Industr ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) ted College (1-4 or 5+ Elementary/Secondary (0-12) uden Complet 21215-0036 18. Mother's Name (First, Middle Father's Name First, Middle, arker å marked (Street and Number or Rural Route Number, 19b. Mailing Address 2 ₽ N Mothe If item 27 20b. Place of Disposition (Name of cemetery, Method of Disposition Baltimore, crematory or other place) Removal from State Burial 2 Cremation 3 It, Zion Cemptery Important: Other Specify: þ 22. Name and Address of F-cility re of Funeral Service Licensee BAI to art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List inly one cause on each line. Approximate Interval Between Onset and Physician Death fedica. a. Multiple Gunshot Wounds mmediate Cause (Final disease .aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical **AMENDED** UNPENDED physician the burial the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 0 has been signed by Yes 2 ✔ No 3 Probably 4 Unknown δ 24b. Were autopsy findings available Completed 24a. Was an Records, prior to completion of cause of autopsy performed? death? No 1 🗸 Yes 2 ✓ Yes 2 certificate page 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Other₄ Be examiner? Nursing Home 5 Residence 6 2 V ER/Outpatient 3 Inpatient this ဥ 1 V Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death After Subject shot Nov 30, 2008 Certification: Yes 2 ✔ No Natura! Pending neral Director: hours after death. Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 4000 Oakford Avenue, Baltimore, Md Suicide determined (Specify) Local Street To the Funeral 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 (Check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

 $\cap$ 

State

Registrar

Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) 0

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Rem 23a) 111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 1, 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Olive N. Pilquist Month Physician 4:20 P M 2008 November 22, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A 2211 W. Rogers Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 100 219-28-7493 1908 Pennsylvania Director July 6, Usuat Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits e how item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be modified as N/A XXYes 2 No Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2211 W. Rogers Avenue Nursing Home 21209 U.S.A. death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. illed within 72 hours after 1 Never Married 2 Married 21215-0036 1 □ Yes 2 No Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 City of Baltimore Statistician permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked othe eny injury or other traumatic event, 20ca. 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Sumame) Be Bertha Manning Lerov Cramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2717 Placid Avenue, Cub Hill, MD Elaine Schneider (daughter) Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 11/26/2008 Fullerton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee ²² Name and Address of Facility Burgee-Henss-Seitz Funeral Home 3631 Falls Road, Baltimore, MD 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Crebo Vaoalen accelent Physician clays /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? Month Year Day 5 Other (specify) 1 Yes 2 No should be detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardorambin disese 1 Yes 2No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes 2 ZNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 200 No nours after death.

nerei Director: After this

filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours a To the Funerei L 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the h 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Da1464 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balls, mil 2 )224 Bank St 3208 RUBERT LIBERTO. 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryl	•	artment o		-	giene Reg. No.?	38871
			1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day Yea	3. Time of Death
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7	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Tow	n, or Location of Dea	h	4c. County of De	ath
			Transitions Health				kesville		Carrol1	
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	Director		232 32 3309	M 21AF   85	Yrs.			06/16	0/1923 W	est virginia
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or L	ocation				10d. Inside City Limits
	l sho	ō	27/4		Baltin	ore				1 ∄Yes 2 □ No
	28e-	Director	Maryland N/A  10e. Street and Number			10f. Zip Cod			10g. Citizen of What	Country?
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	72 hours after death with the Maryland natural', or Items 23e or 28e-f show Jigal Evaninet must be rodified at	Funerai		2. Was Decedent Ever i		Was Decedent	of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No	0- 14. Race - Ar	nerican Indian,
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4	item 27		Jerry Pennington		Db. Place of Disp	2 Lynch		Date	20c. Location - City	
9			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	1	cemetery, cre	matory or other	place)			
ţ	L. Pa tmen tant: tjury		*4 □Donation 5 □ Other (Specify)		Bayview			05/2008		e, Maryland
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	000	2		ddress of Facility (	once Fu	neral Servi	ice, P.A.
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	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical	one)	and manner stated.	mination and/or i			uned at the time,		
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				cense number		29d. Date signed (Mo	O &
			1 //-				43725		12111	- 0
	4		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	Print)	Westmi	niter	MD 21	157
			31. Date filed (Month, Day, Year)	32. Registrar's S		Lucch	· V · W · W	(0 (0)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 📝 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death E11a Marie Potter December 3, 2008 2:40 ам 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Health System Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 💢 F Months Days Hours 212-40-7938 66 2/23/1942 MD Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits Harford Churchville 1¥Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Timothy Drive 21028 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ∐Yes 2**X** No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Webb Ella Linda Durocher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Crowe / Son 303 Timothy Drive, Churchville, MD 21028 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Ardent Cremation Services 12/5/2008 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any leading to annual cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CMS Emphysema 21210 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 XNo Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide

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permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglent Important: If item 27 is marked other tha any injury or other traumatic event, It alone.

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Hospital or Attending within 24 hours after deat To the Funeral Director:

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4 Homicide

29b. Signature and title of certifier

30. Name and address of person

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29a. Certifier (Check only one)

State

Registrar

31. Date filed (Month, Day, Year)

Medical

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

eted cause of death (Item 23a) (Type, Print)

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Division or Vital Records, P.O. Box 68760,

**Physician** 

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment; if fren 27 is marked other than "natural" any injury or other trainment.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy perform 1∐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Location (Street and Number or Rural Route Number, City or Town, State)

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifie

5 Pending investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) ASON R. MOCK, JOHNS HOPKINS BAYVIEW HOSPITAL, 4940 EASTERN NEWE, BALTIMORE, MARYLIND

2008

State Registrar

31. Date filed (Month, Day, Year)

DEC 05

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

32. Registrar's Signature

amend #12&15 Per Ana BD C887 1/08/199 JH Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 26, 2008 2:49 AM M John Russell 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept 13, Year) 925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. Months Days Hours 1 X M 2 □ F Mary Tand 83 218-16-7074 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20688 11740 Asbury Circle #1201 USA 12. Was Decedent Ever in U.S. Armed Forces? TYPES 2 240 If Yes, Give 43 44 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Specify: 43-46 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk College (1-4or 5+) Elementary/Secondary (0-12) 12 11 salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Waters Russell Mary Naomi Davies 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Flo Russell/spouse 11740 Asbury Circle #1201 Solomons, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 □ Other (Specify) Licensee 21. Signatur of Suneral Serv State Anatomy Board 655 W. Baltimore Street Director 0 Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Tales prime

Due to (or as a consequence of): ulmonay disease or condition resulting in death) years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

**Physician** /Medical Examiner

Department of Heath a importent: If item 27 is eny injury or other traisons.

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Baltimore, Maryland 21215-0036

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25. Was case referred to medical

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Medical

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records.

or Attending Physician:

To the Hospital within 24 hours e To the Funeral C completely filled

autopsy performed? 1 ☐ Yes 2 XNO 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

26. Place of Death (Check only one) fy)

1 ☐ Yes 2 No	Hospital:	ER/Outpatient	3□ DOA	Other: 4 Nursin	ng Home	5 Residence	6 ☐Other (Specif
Manner of Death  18 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	280	I. Describe how inj	ury occurred
o Carrier investigation	n I		M	1 Ves 2 No	1		

6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) Additional Examiner: On the basis of examination and/or investige and manner stated.	urred at the time, date and place, and due to tr lation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
29b. Signature and this in perphasis	29c. License number D46419	29d. Date signed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print)

100 HOSPITAL DRIVE, PRINCE PREDERILIC, MD 20678

State Registrar

LETCHFORD MD
32. Registrar's Signature A HARLENE 31. Date filed (Month, Day, Year) DEC 0 5 2008

within 24 hours et To the Funerel D completely filled i

Hospital

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Nicholas J. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only

DEC 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

32. Registrar's Signature

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7401 Osler Drive

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

118269

29d. Date signed (Month, Day, Year)

11.26.08

Towson, Md 21204

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25, 2008**Physician** 1:00 PM M November Elmer Rosenberger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☑ M 2 ☐ F 9 1916 Maryland 92 July | Director 212-01-7007 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventhur must be redthed at 1 X Yes 2 ☐ No Director MD **Baltimore** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number death with 21221 USA 229 Sandhill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 EYes 2 □ No If Yes, Give 42-4 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: white 42-46 Completed by 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If them 27 is marked other than "nr any Injury or other traumatic event, the Medica. Elementary/Secondary (0-12) College (1-4or 5+) 10 letter carrier postal system 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland Be Anna E. Schwindel John W. Rosenberger P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2300 Dulaney Valley Road Towson, MD Stella Maris Hospice 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature Funeral Sui State Anatomy Board 655 W. Baltimore Street irector Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** END STAGE DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Hlnknown signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t perform certificate 1 ☐Yes 2X No of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Nother (Specify)} \) Hospital: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Attending Division 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ö To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one) X Nurse Practitatorier stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP

State Registrar

DHMH 17 Rev 1/2001

ate 31. Date filed (Month, Day, Year) trar DEC 0 5 200

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 20a, b, c, 22 per fh, 1886, 12/16/08dhb

Certificate of Death

Reg. No. for State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 3.00 Zoob (1bext /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner SALTIMORE WASHINGTON MEDIZAL BURNIE ANNE ARUNDE TIE CHUTE? 6. Sex If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1**X** M 2□ F Months Days Hours Min. Virginia 72 Director 224-40-1496 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "wadical Evanders" rust be notified at 1 ☐ Yes 21 No Director Anne Arundel Severn MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with USA 1734 Village Square Circle 21144 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 □ Yes 2 🖺 No 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify <u>^</u> Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) filed withir Hygiene. Dept of Corrections correctional officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be Cora Barrington George Roberts ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Is any injury or other traun 59 S. Gordon Street Alexandria, VA 22304 Ricardo Roberts/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans 12/15/2008 Cheltenham, MD 4□Donation <del>5Mother (Specify)</del> in state ) Director The and Address of Facult Trickland Funeral Services Sicense de, 21. Signa ure of Juneral Serv 6500 Allentown Rd., Camp Springs Approximat Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTICEMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MEUNDHIT Sequentially list conditions, if any leading to make the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed METASTATIC physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 ☐ Other (specify) signed by the a ld be detached for P.O. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an The law cate has t page 2 s autopsy performed? 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 □No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) ure and title of dertifier 29c. License number 29b. Signa November 28-2008 ME 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) en Barne MD piral toc

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day

Year)

2008

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32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month AM December 2008 /Medical Osborne Robinson, Sr 0806 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Year I If Under 24 H Date of Birth (Month, Day, Year) 1 30 19 Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 17☑M 2□F 213-26-9410 78 Director 1930 MD Usual Residence of Decedent 10a. State 10h. County 10c City Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 NYes 2 No Directo MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1425 Homestead Street 21218 U S Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23. Funeral Α 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 Specify. Black 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unk Elementary/Secondary (0-12) College (1-4or 5+) 10th grade <u>Maintenance Supervisor</u> N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 Is marked any Injury or other traumatic ev Sandy Griffin Myrtle Griffin ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Myrtle Robinson-Daughter 1425 Homestead Street Balto, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ↑ ☐ Other (Specify) Trinity Cemetery12-8-2008 Balto, MD 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee Granfa Melain 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 50 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö a∏Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2□No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ 1 | Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of partifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASH OHARAN 32. Registrar's Signature ALATHIL 1000 31. Date filed (Month, Day, Year) State

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ŕ	4a. Facility Name (If not institution,		)	0	or Location of Death	1	4c.	County of Dea	
	,		ge (In yrs. last b	irthday) If Under 1 Year		8. Date of Bir (Month, Da	th ay, Year)	N/ 9. Bir	Rhplace (State or Foreign ountry)
	None Usual Residence of Decedent			Yrs. 2		Novemb	er 2	4,2008	Maryland
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Director	10e. Street and Number			10f. Zip Code	C.		10g. Citi	izen of What C	country?
	4413 Moravia	Road Apt		21200				J.S.A.	oriona Indian
	11. Marital Status  1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	?	13. Was Decedent of If Yes, specify Cut	ban, Mexican, Puert	o Rican, etc.)	)-	14. Race - Am- Black, Whi Specify:	
	15. Decedent' (Specify only highest		168	a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of wor	king	16b. Ki	ind of Business	s/Industry
Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Infant	<del>9</del> 0)			Infa	nt
מפס	17. Father's Name (First, Middle, L Benjamin	,	ıl and		18. Mother's Nan Ash		, Maiden	Sumame) Park	er
	19a. Informant's Name/Relationsh Ashley Parker -			b. Mailing Address (Stree 4413 Moravia		rai Route Numb ot 6 Bal			
	20a. Method of Disposition		20b. Place o	of Disposition (Name of early, crematory or other plants	T	Date		ocation - City or	
	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	•	Zion Cemete	ery Dec	ember 5,	2008	Balt	imore, MD
	21. Signature of Funeral Service L	icensee		22. Name and Addr	ess of Facility R	altimore	. Ma	aryland	21214
	Town have		Lander	Loopand		Inc. E	O F	lanford	DY
	23a. Part 1. Enter the disease, or on shock, or heart failure. List of	complications that caused	d the death. Do		J. Ruck,	Inc. 53	305_F	larford	Rd. Approximate
	shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on each li	line.	not enter the mode of dy	J. Ruck, ring, such as cardiac	Inc. 53 or respiratory a	305_F	larford	Rd.
	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each li	line.	not enter the mode of dy	J. Ruck,	Inc. 53 or respiratory a	305_F	larford	Approximate Interval Between
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician** 6:10 AM M 2, 2008 Nancy Ratcliff /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 08/27/1916 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min England 1 □ M 2 🛛 F 92 578-50-4187 Director Usual Residence of Decedent 10c. City. Town or Location 10a State 10h. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic event, the Medical Examplement or other traumatic events are other traumatic events. Director 1 TYPYes 2 □ No MD Prince Georges Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20737-United States 5506 63rd Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Britanica Publishing Elementary/Secondary (0-12) College (1-4or 5+) Sales Person 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Faulkner Edith Martin ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Ratcliff/Son 5506 63rd Ave. Riverdale, MD 20737-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec 4 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licensee 1401533 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsi Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit ine Due to (or as a consequence of) Box 68760, Physician/Medical attending p as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) P.0. detached 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed: page certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭ZNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely filled in pletely fil death. 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Shama

31. Date filed (Month, Day, Year)

DEC 05

6/en

rd. Silver Spring, MD 20910

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

2008

1500

Forest

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 12:45P M IRA ROSS DECEMBER 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04/06/1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F **Funeral** Months Days 217-34-7341 79 NY Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examinal must be notified at 1 ☐ Yes 2 No Director HARFORD **ABERDEEN** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2400 POST ROAD, TRAILER 5 21001 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M/Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No WHITE Specify: è 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ELECTRICAL & College (1-4or 5+) 5+ filed withir Hygiene. Elementary/Secondary (0-12) MECHANICAL ENGINEER ENGINEERING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL ROSENTHAL BETTY GARDEN Baltimore, Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit, Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trau 2400 POST ROAD, TRAILER 5, ABERDEEN, MD MAMIE EVANS / FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 12/04/2008 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD 21. Signature o Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to for as a consequence of Examiner Seque Rally list of dilicing if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Waş an cate has bage 2 s autopsy performed? Yes 2 No certificate atera 1 □ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Propatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) illan K December 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeako 31. Date filed (Month, Day, Year) 3 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28c, per ME g886 12.5.08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For

UU	0000-
	3. Time of Death
Year	1110000

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylanc Department of Health and Mental Hygiene. Income agree occurs of the properties of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Patient Known as Baxton Summer Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

	1 - State Registrar		Certifi	Re	Reg. No. 4 0 0 0 0 0 0 0					
	1. Decedent's Name (First, Middle, Last,	)			2. Date of Death	h Day Year	3. Time of Death			
ın al	Braxton D. Sumner	. Jr.			November	00 0 - 0	14:00 M			
aı er	4a. Facility Name (If not institution, give	street and number)	4b.	City, Town, or Location of Deat	n	4c. County of Death				
	Sinai Hospital of	Baltimore	P	baltimore City		n/a				
	5. Social Security Number 6. Se 118-76-1146	x 7. Age (In yrs		Under 1 Year If Under 24 Hrs. onths Days Hours Min.	(Month, Day,	8. Date of Birth (Month, Day, Year) 9. Birth Courth, Day, Year) Ma				
<b>.</b>	Usual Residence of Decedent  10a. State  10b. County	10c. C	ify, Town or Locatio	n			10d. Inside City Limits			
cto	Md n/a		Baltir	nore			1 2 Yes 2 No			
<u>ir</u> e	10e. Street and Number		11	Of. Zip Code	10	ng. Citizen of What Cou	intry?			
<u>~</u>	3828 Elm Avenue			21211		USA				
Be Completed by Funeral Director	11. Marital Status  1.☑Never Married 2☐ Married 3☐Widowed 4☐Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	If Yes	Decedent of Hispanic Origin? (Ss, specify Cuban, Mexican, Puer (es 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify:				
leted	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Decedent's (Give kind life. DO N	s Usual Occupation of work done during most of wor IOT use retired)	rking	16b. Kind of Business/Ir				
щ	Elementary/Secondary (0-12)	College (1-4or 5+)		worked	-	n/a				
S	17. Father's Name (First, Middle, Last)		Never		ne (First, Middle, N					
ă	Braxton Dexter Su	mnor				,				
ို	19a. Informant's Name/Relationship (7)		19h Mailing Ad	SUE Idress (Street and Number or Ri	Ripley ural Boute Number	City or Town State 7i	in Code)			
	Mr. Ronald Sumner	•		lm Avenue Balti			·			
	20a. Method of Disposition	20b.	Place of Disposition cemetery, cremator	(Name of		20c. Location - City or T				
	1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		**		5/00	D-1+4	M 1 1			
	21. Signature of Funeral Service Licens		22. Na	Cemetery 12/	2/08     udon Port	Baltimore,	_Maryland			
	1 Turner	1/20	2620	) Wilkens Ave.	Baltimore	Norwland	21220			
	23a. Part1. Enter the disease, or composhock, or hear failure. List only of	lic ons that caused the dea	ath. Do not enter the	e mode of dying, such as cardia	c or respiratory arre	est,	Approximate			
	shock, or heaf failure. List only o Immediate Cause (Final	7		1			Interval Between Onset and Death			
	disease or condition resulting in death)	a. Due to (or as a conse	rdiac as	7851			1 day			
		mu Hale	1 0	actures			1 day			
ler	Se wentially list conditions if any, leading to immediate	b. Due to (or as a conse		ACT THE S	-	[ CMI	· ang			
Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. fall down	1 multio	le staire	m	/\ [\]	1 Laur			
Exa	resulting in death) Last	Due to (or as a conse	equence of):	10.11.2	) ~	Y MEDICAL EXAMINER	1 4			
ca		d		· · · · · · · · · · · · · · · · · · ·	CATION APPROVED O	a				
edi				GSW1,						
Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregi 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 ☐Ecto	opic pregnancy er (specify)		23d. Date of deliv Month	very Day Year			
y Ph	Part II. Other significant conditions co	intributing to death but not re	esulting in the underl	ying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?			
ba	mental retar	dation			1 □ Ye	es 2.XXNo 3.□Pro	bably 4 Unknown			
Set					24a. Was ar		opsy findings available			
E C					autops	ned?   death?	ompletion of cause of			
Ö	25. Was case referred to medical			26 Place of De	1 Yes 2 ath (Check only one	2 X No 1 □ Yes	2 <b>/2</b> /No			
o Be	eyaminer?	Hospital: 1 Inpatient 2[	☐ER/Outpatient 3	Other		nce 6 Other (Spec	ify)			
: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	28d/Describe ho	w injury occurred				
atior	1 ☐ Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	Work? 1 ☐ Yes 2X No		wn stairs in	the dark			
Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At building, etc. (Spec	cify)	factory, office	28f. Location (Str. City or Town 3828 Elm	reet and Number or Rui State) BYC, Ballima	ral Route Number, Ire, MD 21211			
dical (	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exam	vsician: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, death occ nation and/or investi	curred at the time, date and plac gation, in my opinion, death occ	e, and due to the ca	ause(s) and manner as	stated.			
Me	29b. Signature and title of certifier	1		29c. License number	29	9d. Date signed (Month	, Day, Year)			
	1/1/1/1/1	/		RES -000	1	Vovember 2	8,2008			

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 0 5 2008

30. Name and actress of person who completed cause of death (Item 23a) (Type, Print), Hubeeba Park, MD Sinai Hospital of Ballimore

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Carol Ann Stroh 28, NOVEMBER 2008 03:58 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ F 219-44-6384 June 16, 1945Balt., Maryland Director Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examine remarker ruttind at once. Director 1 ☐ Yes 2 No Baltimore Maryland Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14427 Thorton Mill Road 21152 of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 21 No Specify white 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade comp 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry William Koch Anna Marie Jacobs ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emory P. Stroh, Sr./ husband 14427 Thorton Mill Road Sparks, Maryland 21152 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Joseph
Cenetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State December West 4 ☐ Donation 5 ☐ Other (Specify) Howesville, Virginia 2, 2008 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 21. Signature of Funetal Service Licenses 2325 York Road Timonium, Maryland 21093 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician odena disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami burial-tran and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) the 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No cate has to 24a, Was an autopsy certificate 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1∐Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA this Medical Certification: To funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation Natural death. thours after death.

uneral Director: A

sly filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hour.
Se Funeral Dir.
Stilled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of per

31. Date filed (Month, Day,

Yeal

Box 68760,

P.0.

Division of Vital Records,

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on who completed cause of death (Item 23a) (Type, Print

22/Registrar's Signature

670/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 2__ 2008 5:18 AM Charles Howard Sims, Sr. Dec. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Air Harford Bel 8. Date of Birth (Month, Day, Year)

Jan. 2,1931 Maryland 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1**X** M 2□ F 218-26-0410 77 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County a or 28a-f show 1 ☐ Yes 2√ No Harford Director MD Jarrettsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1432 Jarrettsville Road 21084 United States "natural", or Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ▼□ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo Specify White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Lombardo's Elementary/Secondary (0-12) College (1-4or 5+) Butcher/Meat Cutter 12 Market permit. Pages 1 and 2 should be filed beatment of Health and Mental Hygis Important; If item 27 is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harrison Thomas Elizabeth Forwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Sims- Spouse 1432 Jarrettsville Rd. Jarrettsville MD21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & De Cremation Syrs - Belair De 22. Name and Address of Facility Dec. 6,2008 Forest Hill, MD 21. Signature of Funeral Service License Evans Funeral Chapel & Cremation Services - Bo 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to ( r as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): attending physician Physician/Medical the use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Fims Charles Howard Mogginsion or Vital Records, P.O. Box 6876

31. Date filed (Month, Day, Year)
DEC 0 5 200 Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

DOU. D

5

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C, 5 W.

32. Registrar's Signature

29c. License number

mocphA.

D3555)

29d. Date signed (Month. Day, Year)

Decomber 2, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Edna Diane Sigal 3:32.4M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. Cop 4b. City, Town, or Location of Dear Examiner oha (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 213-38-6626 1□M 2XF Months Days Hours Min. Aug 1940 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show at Maryland Harford County Bel Air permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified a 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 United States 120 A. Royal Oak Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Sales Clerk Elementary/Secondary (0-12) College (1-4or 5+) Obkesbury Book Store N/A 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alma Davis Russell White ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3864 Schroeder Ave. Perry Hall, MD 21128 19a. Informant's Name/Relationship (Type. Print) Mr. Robert White (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dec. 9, 2008 Parkwood Cemetery Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services — I 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complications to a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical a consequence of) Examiner sclenter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner that initiated events resulting in death) Last or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by Par II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 4 No 24a. Was an autopsy perform After this certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of eath
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 □ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ō Hospital 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) ne and a leted cause of death (Item 23a) (Type, Pri 31. Date filed (Month, Day, 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 3 Janis Stout 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Kaltimore Washington Medical Center 8. Date of Birth (Manth, Day, Year) 10/14/1920 Social Security Number Hours 1 □ M 2 🔀 F Months Days 219-30-8175 Tennessee 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21221 338 Nicholson Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Lowe Joseph Wade McEwen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Riggs Avenue, Severna Park, Maryland 21146 Kathi Diver (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 12/06/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Survice to ensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 29a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cident Immediate Cause (Final LUDVAS lease or condition sulting in death) Due to (or as a consequence of) Sequentially list conditions, if any conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 □ Yes 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined

law requires that the death certificate be executed physician and s the burial-trans Box 68760, as attending properties for use as P.0. cate has been signed by the page 2 should be detached Division of Vital Records, certificate |

**Physician** 

Examiner

/Medical

Examiner Physician/Medical à Completed Be Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

Completed by

Be (

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Exercited on the Insulfical

Baltimore, Maryland 21215-0036

3,0

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

tal Drive, Glen Burnie, MD. 30-Name and address of person who completed cause of death (Item 23a) (Type, Print) Year

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, State Registrar

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** William Frederick Schultz ecember 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimone oseda Samore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day October 19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Min. Months 1 □ M 2 □ F Baltimore Co., Md. 82 217 26 0264 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Injury or other traumatic event, the Mudical Exeminar must be notified at 1 ☐Yes 2 X No Director Maryland Baltimore Baltimore County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō USA 21220 10248 Bird River Road or items 23a, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify þ Specify: White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4or 5+) Body & Fender Mechanic Automotive 12 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John F. Schultz Rose Zimmerer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6950 SE 190 Court Morriston, FL. 32668 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other tra William R Schultz (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Depember 8 2008 Holly Hill mem. Gdns. Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Licenses 22. Name and Address of Facility
Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequency of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Due to (or as a consequence of) attending physician and for use as the burial-trar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a o □ I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 Who page certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this funeral ( 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check or one) and manner stated the 29b. Signajure 29c. License number 29d. Date signed (Month, Day, Year) 2

Baltimore, Maryland 21215-003

Box 68760,

P.O.

Division of Vital Records,

Hospital or Attending Physician:

Registrar

30. Name and add

31. Date filed (Month, Day, Year)

James



cause of death (Item 23a) (Type, Print)

DO 9000 Frank

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Mary	land / Depa <i>Ce</i>	artment o <i>rtificate</i>				giene Reg. No.	2008	33338
			Decedent's Name	(First, Middle,	Last)						2. Date of Dea	ath	Vens	3. Time of Death
-	Physici /Medic		POYCE	Eug.	· ~ ~ ~ \$	TIFE	ELER				nonth	Day 29	Year 2005	1:35 PM
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and the			7221	Golden	Ring R	local		13	ochono	ine			BALTIM	345
	Funeral		5. Social Security Nu		. Sex		n yrs. last birthday)	If Under 1	Year If Ur Days Hou	nder 24 Hrs.	8. Date of Birt (Month, Day	1		place (State or Foreign
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☑ Widowed		12. Was De Armed F d 1 ☐ Yes If Yes, G Year or	orces? 2 ☑ No live	r in 0.5.	if Yes, specify		ecify:	pecify Yes or No- p Rican, etc.)	Ì	Black, White, Specify:	
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Baltimore,	permit. Depart Import any inj		21. Signature of Full	neral Service L	V- D		I	2. Name and A Ouda – Ru 7922 Wi	ck Fui	nera1	Home of	Dund	dalk, Ir and 21	nc. 222
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D. Box	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Physician/Me	23b. Was decedent in the past 12 I 1 Yes 2 9 Unknown	months?		birth 2 [ gnant at tim	Fetal death 3	⊒Ectopic preg ⊒ Other (s <i>pe</i> c				23	3d. Date of deliv Month	ery Day Year
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on	ding 1 J. After funer	ion	1 Natural	5 Pending investiga	(Mo	nth, Day Ye	ea <i>r</i> ) Injury	м	. Injury at Work? 1 ☐ Yes	2 □ No	Eddi Boddilbo i	ow injury	COCCITICA	
2	deatl deatl ctor: y the	ica	2 ☐ Accident 3 ☐ Suicide	6 Could no	t be	e of injury -	- At home, farm, st				28f. Location (S	treet and	Number or Bur	al Route Number,
Θ	after after Dire	Certification:	4 ☐ Homicide	determin	eu buil	ding, etc. (5	Specify)				City or Tou	n, State)		,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	1 <b>Certifying</b> 2 Medical E	xaminer: On the	ne best of m basis of ex	ny knowledge, dea amination and/or in	th occurred at nvestigation, in	the time, da my opinion	ite and place n, death occu	, and due to the rred at the time,	cause(s) a date and	and manner as s place, and due	stated. to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and	title of certifier				29c. L	icense numl	ber		29d. Date	signed (Month,	Day, Year)
	->=0		) IAIO	rd. K	alle n	5		D	3/295	_		111	28/08	
÷	5-		30. Name and addre	ess of person w	ho completed car	use of death	n (Item 23a) (Tvne							
	5		Wende	Klaes	an and	4	convert		10	Saltan	nore 1	nd	21206	
	Sta	ite	31. Date filed (Mont		_	registrar's		Ø			-		OL.	
	Regist	_	£	DEP A D	ZUUD A	Aller.	All B	98 4 B						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month ))ec 11:30 AM ean 2008 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Baltimore Heigher If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Hours Min. (Month, Day Tune 4 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-32-3171 1 ■ M 2 ■ F Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at MOTE 1 es 2 No by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 10 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Blac 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Educato 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental I Importent: If Itam 27 is marked o any injury or other traumatic eve William Anderson Pecola Lun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ZIII Danard SMith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Coc. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician ar Records, P.O. Box 68760, Completed by Physiclan/Medical attending pt I for use as tl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 sesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and utto of certifier

31. Date filed (Month, Day, Year)

/16/na>

DEC 0 5 2008

8/2150CE

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

32. Registrar's Signature

30. Name an Address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Marylan	-				lental Hy	giene 🤈 🏻	18	38890
			State Registrar		Cei	rtificate	e of Do	eath		Reg. No.		
	Dhysisi	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
	Physici: /Medic		MARGARET ELIZA	BETH SHEPPAR	DD	,			DECEMB		208	2:55 A M
	Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City,	Town, or Lo	ocation of Death		4c. County	of Death	
1			UPPER CHESAPEAKE	MEDICAL CEN	TER		L AIR			HARF		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under Months		f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		<ol> <li>Birthp Cour</li> </ol>	lace (State or Foreign atry)
	Director		212-42-2005	65	Yrs.				<u>May 30</u>	, 1943	Mar	yland
	w		Usual Residence of Decedent  10a, State 10b. County	10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Limits
	aryla sho	'n	,									1 ∐Yes 2√∑ No
	he M	Director	Maryland Harford	Be	l Air	10f, Zip	Codo			10g. Citizen of	Alban Carre	
	with t		10e. Street and Number	a							What Cour	nu y :
	death with the Maryland ms 23a or 28a-f show rrust be notified at	Funeral	1400 Southview Roa		C 12 1		1015	ania Origin? (Cn	anifu Van ar Na	USA 14 Por	e - Americ	ann Indian
9	item item	Ë	11. Marital Status  1 Never Married 2 Married	. Was Decedent Ever in U Armed Forces? 1 ☐Yes 2€ No	.3.	If Yes, spec	ify Cuban,	anic Origin? (Sp Mexican, Puerto	Rican, etc.)	Bla	ck, White,	
38	rs aft	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	2 <b>X</b> No	Specify:		Specif	y:	.To - 1
28	hou trura	ed	15. Decedent's Educa		16a. Dece	dent's Usua	al Occupation	on		16b. Kind of B		White dustry
₹ <del>C</del> E	in 72 n "ne Nedik	plet	(Specify only highest grade of	completed)	(Give	kind of wor DO NOT us	rk done dur se retired)	ring most of work	ing			•
755	within jiene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	maker				Own Ho	me	
Q 0	filed I Hygi other ent, t	BeC	17. Father's Name (First, Middle, Last)				11	8. Mother's Nam	e (First, Middle			
	Id be lenta ked ic ev	To B	Bernard George Wa	mer				Doris El	izaheth	n Doerir	ncr	
Mary	should be I and Mental s marked o umatic eve	-	19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address		d Number or Rui			_	Code)
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	nd 2 alth a 27 is r trai		Michelle McFadden	/ Daughter	414 1	Rarns	St	Bel Air	Marla	and 2101	Λ	
	s 1 a f He ifem othe		20a. Method of Disposition		Place of Dispo				Date	20c. Location		wn, State
75	Page: ent o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	noval from State				dn   12-8-	-08	Bel Air	· Mai	arl and
altin	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmer must be notified at once.	1 4	21. Signature of Funeral Service Licensee	130							, Mal	Гутана
- B	permit. Departi Import any inj	6 6	Russ Cli		Mo	cComas	s Fund	of Facility eral Hon ury Road	ne, P.A.	rdon Ma		21000
			23a. Part 1. Enter the disease, or complica	tions that caused the deat	th. Do not ent	ter the mod	le of dying,	such as cardiac	or respiratory a	rrest,	плта	Approximate
	Dhaeisian	0.3	shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	101	1.		0				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	TUTI		uny	(and	X			
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10		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a sonseq	ruence of).							
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50	t the	hys	9 Unknown	9 🗆 Unknown								
Ğ. π.	w requires that the death cerl s been signed by the attendin should be detached for use a		Part II. Other significant conditions contr	ibuting to death but not res	sulting in the u	nderlying ca	ause given	in Part I.	23e. Did t	obacco use con	tribute to th	ne cause of death?
# 5 E	quires in sig	Completed by	Coronary A	tery Di	seas	2			×	Yes 2 □ No	3☐ Prob	ably 4 Unknown
200	law rec as bee 2 shou	lete	Hunoctonsis	00					24a. Was	an 24b.	Were auto	psy findings available
<b>25-26</b>	he la e has	шć	- Type Por	<i>71. 7 7 7 7 7 7 7 7 7 7</i>					auto perfo	psy prmed2	prior to co death?	mpletion of cause of
Margarel Vital Record	in: T ificat or, pa		25. Was case referred to medical					00 Dinn of Door	1 🗆 Yes	-	1 ☐ Yes	2 No
$\leq \bar{\epsilon}$	Physician: The law this certificate has be all director, page 2 st	Be c	examiner?	spital: 1 Inpatient 2	TD/Outpotion	** 2 D DC	100	26. Place of Deat			- (0	
	Phys rr this eral dir	Certification: To	27. Manner of Death	28a. Date of Injury	28b. Time of			4 Nursing Ho		how injury occur		у)
Se	ding P. h. After funera	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	м	8c. Injury a Work? 1 □ Ye	s 2 No		,,		
Sisi	Attending r death. ector: After oy the fune	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, str	eet, factory			28f. Location (	Street and Numi	per or Rura	il Route Number,
3	or / after Dire	erti	4 ☐ Homicide determined	building, etc." (Speci	fy)				City or To			,
2	Hospital 24 hours Funeral stely filled		29a. Certifier 1 Certifying Physic	cian: To the best of my kno	owledge, deat	h occurred	at the time	date and place	and due to the	cause(s) and m	anner as s	tated.
5	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examine one)	er: On the basis of examina and manner stated.	ation and/or in	vestigation	, in my opir	nion, death occur	red at the time,	date and place,	and due to	the cause(s)
- /	Fo the within 2 fo the comple	Me	29b. Signature and title of co tifier			290	. License r	number		29d. Date signe	d (Month,	Day, Year)
	- >		1 au				000	16091	2	Dece	nho	14 2mg
	1.		30. Name and address of person who com	pleted cause of death (Iter	m 23a) (Tvne	Print)		4 + 11		700	· NUC	1,000
	0		Vankata Pars	a 6000 S	a, Lh 1	tino	20R	1. Suite	200	Rol 1.	im	021014
	Sta	ite	31. Date filed (Month, Day, Year) DFC 0 5 2008	32. Registrar's Signa	ature	LI LUCI	MIL	1.) 04146	200	Jack Jack	1111	11/10
	Registr		NFC 0 5 2008	Alexand Al	65000	Same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same o						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** James Earl Scharper 12:20 P.M 29, 2008 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 129 Severn Wav Anne Arundel Arnold 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/21/1915 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F Months Hours Min Maryland 93 705 05 0088 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Tyes 2 X No Anne Arundel Annapolis Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85 Manresa Road #234 21409 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖺 No Specify. ģ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer CSX Railroad 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A. Scharper Marie L. Griffin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Susan Garreis / Daughter 129 Severn Way Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12/02/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. nonwounder 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** acollow /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical the as yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Ciceples Other: 4 Nursing Home 5 Residence 1 Yes 2 No Hospital: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 27. Mannet of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D57028 12-01-68

State Registrar venue # 231

Annoypolis MD 21401

600 Ridgely

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chara M.D.

2008

31. Date filed (Month, Day, Year)

DEC 05

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg, No. 2000 388					
	Physici	an	Decedent's Name (First, Middle, Last)	2 Date of Death	Day Year 29, 2008	3. Time of Death	
	/Medi	cal	F1orence Seward  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	6:35 P ^M
	Examir	ier	Greater Baltimore Medical Center	Towson		Baltimo	re
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months   Days   Hours   Min	8. Date of Birth (Month, Day, Y	(ear) 9. Birthp	lace (State or Foreign
	Director		217 03 1636	5.	11/16/1	.913   Mar	y1and
	<b>Daltimore, Maryliand ∠1∠13-UU30</b> permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "A direl Event hat List be refined anone.	Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town o			1	0d. Inside City Limits
			Maryland Anne Arundel Balt	imore	100	0.00	1 ☐ Yes 2 🕱 No
			9 Short Street	10f. Zip Code 21225	109	g. Citizen of What Coun	try?
. 1				13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ	
Florence			1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates:	1 □Yes 2 🖾 No Specify:	o riioari, etc.,	Specify: Wh	ite
25			15 Decedent's Education 16a. D	ant's Education 16a. Decedent's Usual Occupation 16b		o. Kind of Business/Industry	
121			Elementary/Secondary (U-12)   College (1-4or 5+)	live kind of work done during most of work te. DO NOT use retired) omemaker	Villa	Own H	OMA
7 5			17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma		Onic
J :	yuld be Menta arked atic ev	TO B	Frank Damesyn	Sta	anislava J	Jaworski	
Z	12 sho h and 7 is m traum			ailing Address (Street and Number or Ru			· · · · · · · · · · · · · · · · · · ·
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Sewand	Pages nent of unt: If its ury or o		Laburar 2 La Cremation 3 La Removal nom State		04/2008 E	Baltimore,	Marvland
	permit. I Departm Importa any inju		21. Signature of Funeral Service Licensee	OO Manage and Address of Coults.		cal Service	
		î e	23a. Part 1. Enter the disease, or complications that caused the death. Do not	4001 Ritchie High	<u>vay Balti</u>	<u>imore, Mary</u>	
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				Interval Between Onset and Death
M/8	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	M Difficite C	dirhs		
$oldsymbol{arphi}$	ertificate ing physi e as the l		IF FEMALE:				
O Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as:	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death  4 □ Pregnant at time of death  9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year
ords. P	w requires that the de to be signed by the should be detached full to be detached full to be should be detached full to be should be detached full to be should be detached full to be should be detached full to be should be detached full to be should be detached full to be should be should be detached full to be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be sho	۵	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobad	cco use contribute to th	e cause of death?
al Rec	n: The law ficate has b rr, page 2 sh	Completed		27.7	24a. Was an autopsy performe	24b. Were autor prior to cor death? No 1 □ Yes	osy findings available npletion of cause of
<u> </u>	Physician: this certific	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpa	Othor:	th <i>(Check only one)</i> ome 5□ Residenc	ce 6 ☐ Other (Specify	4)
o D	ng Ph fter th meral	on: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) Inju	e of 28c. Injury at	28d. Describe how		,
Division of Vital Becords	Hospita 4 hours Funeral	Medical Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 □Yes 2 □No	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
			29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dependence on the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desi	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as si and place, and due to	ated. the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier	29c. License number		. Date signed (Month, L	
	1	9	30. Name and address of person who completed cause of death (Item 3a) (Ty	11) D-4472 11) 6535 N.C.V.	5 /	1-30-2	7008
	Ve		Milzhell Schwarza	10 6535 N.CL	weles	+STES	SO MPAINO
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 5 2008	de			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Irma V. Stewart 7:25 A. December 2, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Morningside Assisted Living Hanover 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 ☐ M 2 🕱 F Months Days Hours Min Maryland 85 Director 219 10 4516 04/22/1923 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕱 No Director Anne Arundel Hanover Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 7853 Old Telegraph Road 21076 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 □Yes 2 🕱 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Health Aide 8th Home Nursing Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Brogan Viola Sims မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Thompson / Son 406 Catherine Avenue Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 12/05/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 3.a. Part 1. Enter the disease, who shock, or heart failure. I st unity Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on earl line Immediate Cause (Final **Physician** In en Year disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to or as a conse mence of To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Î ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 AK 1 □ Yes 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home Assile 1 | Yes 2 | 1 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 6 ☐ other (Specify) 5 ☐ Residence within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Umural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determi 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State 0 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (_ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 3:00 A. Myrtle M. Spindle 28, November 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 Wallace Ave<u>nue</u> Anne Arundel Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) 01/21/1916 **Funeral** Days 1 □ M 2 🕮 F Months 92 216 28 4566 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Anne Arundel Baltimore Marvland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7 Wallace Avenue 21225 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any inlury or other traumatic event, Ita Fedical Experime 1 ☐ Yes 2 📉 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: ģ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence H. Worley Amelia Whorley ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elaine Moxley / Daughter 7 Wallace Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 12/03/2008 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, of Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DIABETES **Physician** DYETTA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): the attending physician ned for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed To the Hospital or Attending Physician: The law requivaling 4 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 \( \text{Yes} \) 2 \( \text{Yes} \) No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 1 Residence 6 \( \text{Other} \) (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 37111 12/01/08 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. HANOVER ST, BALTIMORE MD 21225 PRAPULL PATEL, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 5 2008 Registrar

08-09103

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Ryan Spitzer Certificate of Death 1- For State Reg. No 3. Time of Death Registrar 2 Date of Death Decedent's Name (First, Middle,Last) Month Day December 3, 2008 Physician/ 1636 hrs Spitzer Matthew Ryan Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia Howard County General Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** 5. Social Security Number 219–06–6826 Foreign 11/07/1975 Months Days Hours 33 Country) Director 1X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 X Yes 2 No Sykesville Carroll once. Director 10g. Citizen of What Country: 10f. Zip Code , 23a or 28a-f 10e. Street and Number **USA** 27184 6302 Hemlock Drive West Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Funer Armed Forces? Never Married 2 XX Married White 2 X No Yes Specify 9 Yes 2 X No specify: f Yes, Give Year Widowed 4 Divorced Examiner 16a. Decedent's Usual Occupation (Give kind of work done 2 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life, DO NOT use retired) Completed Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hyggen.
Important: If item 27 is marked other than "nati College (1-4 or 5+) Flementary/Secondary (0-12) Construction Heavy Equipment Driver 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Glenn M. Spitzer Virginia Houston Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) ٩ 10700 Hillingdon Drive, Woodstock, MD 21163 Virginia Spitzer / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Ardent Cremation Serv 12/5/2008 Hanover, MD Other Specify Donation 5 Doro a Mars al 22. Name and Address of Facility Signature of Funeral Service Licensee 210 a 15 at 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203

Part Linter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Physician failure. List only one cause on each line Death **fedica** a Narcotic and alcohol intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and #1 as noted per ME g886 12/11/08 TT Physician/Medical , perME G886 12.15.08 TT attending physician a for use as the burial X UNPENDED AMENDED 23a,27,28a-f The law requires that the death certificate be 23d. Date of delivery 68760. 23c. If yes, outcome of pregnancy Year Dav Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death Pregnant at time of death 5 Other (Specify) Box Yes 2 No 9 Unknown 9 Unknown the signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö No 3 Probably 4 ✔ Unknown Yes 2 þ σ, Completed 24b. Were autopsy findings available 24a. Was an Records, s been si should b prior to completion of cause of autopsy performed? death? s certificate has b rector, page 2 sh Yes 2 Nο ✓ Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Division of Vital Be Other, Hospital: 1 Nursing Home 5 Residence 6 examiner? Inpatient 2 V ER/Outpatient 3 1 Yes No ပ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification: unk Yes 2X No Natural Pending Fnd 3:30 pm Fd 12.3.08 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10700 Hillingdon Rd Howard County, MD 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide hosue determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day. Year) 29c. License number 29b. Signature and title of certifie December 4, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 1 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Exami

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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	Sta Regist

	For State Registrar	Reg. No. 2 (1 1 8 3 1 3 9 5									
ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death							
cal	Jack Farrell Stidham		December 3, 200	-							
ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deat								
	Seasons Hospice @ Northwest Hospit  5. Social Security Number   6. Sex   7. Age (In yrs. last birth		8 Date of Birth 9 Birt	re hplace (State or Foreign							
	215-22-7728 ¹ ¼ ^{M 2□ F} 80 Y	Months   Days   Hours   Min	(Month_Day, Year) Co	yland							
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits							
ō		nn Oak		1 ∐Yes 2 🛣 No							
irec	10e. Street and Number	10g. Citizen of What Co	untry?								
Funeral Director	3120 Lugine Avenue	21207	USA								
ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-								
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Be Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life, DO NOT use retired)	16b. Kind of Business/	16b. Kind of Business/Industry							
E O	Flementary/Secondary (0-12)   College (1-4or 5±)	Electrician		Construction							
Se C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden Surname)								
To E	James Henry Stidham	Edna	May Mitchell								
-		Mailing Address (Street and Number or Rui	-								
	- 8	12 Old Joppa Road Jo									
		Disposition (Name of y, crematory or other place)  Crematory Inc. 12/0	Date 20c. Location - City or 206/08 Baltimore,								
	21. Signature of Funeral Service Licensee  Thomas Gregor	22 Name and Address of Facility Ho MacNabb Funeral Ho 301 Frederick Road									
-	23a. Part 1. Enter the disease, or complications that caused the death. Do n.			Approximate							
	shock, or heart failure. List only one cause on each line.	lot enter the mode of dying, such as cardiac	or respiratory arrest,	Interval Between Onset and Death							
	disease or condition a. LUNG CANC										
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EX	resulting in death) Last  Due to (or as a consequence of	f):									
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cian	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of dei Month	23d. Date of delivery  Month Day Year							
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Z P	Part II. Other significant conditions contributing to death but not resulting in	23e. Did tobacco use contribute to	the cause of death?								
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Completed by Physician/			24a. Was an 24b. Were au prior to c	topsy findings available completion of cause of							
ĕ		performed? death?  1 \( \subseteq \) Yes 2 \( \subseteq \) No \( 1 \subseteq \) Yes 2 \( \subseteq \) No									
Be (											
ioi	agradual o Li chang	ime of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how injury occurred								
licat	2 Could not be		8f. Location (Street and Number or Rural Route Number,								
erti	4 Homicide determined 28e. Place of Injury - At home, fari	,	City or Town, State)	iwn, State)							
Medical Certification: To	29a. Certifier  (Check only  Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
Med	one) and manner stated.  29b. Signature and title of certifier	29c, License number	29d Date signed /Month	Day Year)							
	DROLLAN KIENE			29d. Date signed (Month, Day, Year)  December 4th 2028							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Smith Avenue Svite 203 Baltimore M										
ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	6									
rar	DEC 0 5 2008 See &	Agents)									

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Division or Vital Records, P.O. Box 68760,	I or Attending Physician: The law requires that the death certificate be executed	one boars.  Director: After this certificate has been signed by the attending physician and I in by the funeral director, page 2 should be detached for use as the burial-transit

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 15:48 MARTIN SCHULTZ Helember 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore OF Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/05/1964 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Numbe **Funeral** Hours 1**X** M 2□F Director 474-80-3539 44 MN Usual Residence of Decedent a or 28a-f show be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Director BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 3209 SZOLD DRIVE 21208 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify. WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LAWYER AT LAW 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAY SCHULTZ CLAIRE FERBER ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SHANI SCHULTZ / WIFE 3209 SZOLD DRIVE, BALTIMORE, MD or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR HAMMUCHOS 12/04/2008 JERUSALEM, ISRAEL 21. Signature o Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hrastamotic Due to (or as a consequence of) Physician/Medical attending for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28855 December 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h 2401 W. BELVEDERE AVENUE, BALTIMORE, MD RHONDA FISHEL 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 05 Registrar

# Samuel Tubbs

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-	Physician /Medical Examiner  Image: Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physicia	Examiner	23a. Pård1. Enter ti shock, or hea Immediate Cause (disease or condition resulting in death)  Sequenties, little of the cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	nt failure. List only (Final in nothers, nmediate orlying injury	pilications that caused one cause in ach ling a.  ue to (or as Due to (or as C. Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as	a consequen a consequen	ce of):	fer the mode of dy		Lalina,		2 D	Approximate Interval Between Onset and Death	) (c)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 600 PM Kandy Taylor 2008 Joven he /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner f Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Months | Days | Hours | Min. | Mar 6, 1958 04 Singi Hospiral

5. Social Security Number 6. Baltimore 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛛 F California 50 544-06-7986 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1y∑Yes 2∐No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 5301 Liberty Heights Avenue 21215 USA items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 □Yes 2X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk 72 (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. fast food industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk f and 2 should be f Health and Mental ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau Crystal Layton/friend 6941 Branch Avenue Baltimore, MD 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 Mother)(Specify) in state 21. Signatur, 1 Juner Lanvice Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Main /Medical Due to (or as a consequence of) CERTIFICATION REPROVED BY MEDICAL EXAMINER **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Minutes The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 minutes Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Ö been signed by the should be detached 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Hepatitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed tage renal disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 No certificate this certific al director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ After this funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 8 00 PM 1 ☐Yes 2 ☑No 120/08 Fall 2 Accident of bed after seizure 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 4017 nursing nome Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal

Vital Hospital or Attending Physician: of within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Patient

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ean

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MCL

M.D. mulean

MD

29c. License number

1+ospital

29d. Date signed (Month, Day, Year)

OF Baltimore

08-09071 Glenda Travers

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Vital Records, P.O. Buysician: The law requires that the de this certificate has been signed by the I director, page 2 should be detached it	Phy	Part II. Other significant cor	nditions contributing	to death but not resu	ulting in the	underlying ca	ause g	iven in Pa	art I.					the cause of debably 4 U	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the sa for cleath.  To Director: After this certificate has been signed by the funeral director, page 2 should be detact	ed by										a. Was ar		b. Were a	utopsy findings	available
ord: aw requas been as been 2 shoul	Completed									45	autopsy perform Yes 2	red?	prior to death? 1 ✓ Y	completion of c	ause of
Rec: The lificate l		25. Was case referred to me	dical			26	.Place	of Death	(Check			INO		-	
/ital ssician his cert directo	o Be	examiner?	Hospital: 1	Inpatient 2 E	R/Outpatie			Other ₄		g Home		esidence		er: Scene	
of ing Plu After t funeral	-1	27. Manner of Death		e of Injury th, Day,Year)	8b. Time o			ry at Wor Yes 2	- I	28d. Di	escribe no	ow injury oc	curred		
Sior Attend r death ector: by the	catic	2 Accident	Pending Investigation 28e. Pia	ice of Injury - At hom	ne, farm, str	reet, factory,	office t	ouilding, e	etc.		cation (St		umber or R	urai Route Num	nber, City
Divisuital or Aurs after ral Dire	Certification:	4 Homicide	Could not be determined (Specif)	_	_										-
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		(Chican chi)	ng Physician: To the be Examiner:On the basis	est of my knowledge s of examination and	e, death occ	curred at the t	ime, d	ate and p	lace, and	due to at the tin	the cause ne, date a	(s) and ma nd place, a	nner as sta nd due to t	ited. he cause(s)	
To the within To the comple	Medical	one) 2 Medical 29b. Signature and title of ce	and manner	stated.				se numbe						onth, Day, Year,	)
		Du me	Jil imo				O.C.	M.E.				Decem	ber 3, 20	800	
$\mathcal{L}$		30. Name and address of pe		use of death (Item 2 Medical Exami	23a)	11 Penn S	treet	t. Baltin	nore. M	ID 212	201	-			
		Donna M. Vincenti	(ear) 32.	Registrar's Signature		A Jan									
Regis	tate trar	nro	0 5 2008	ANDER &	The party										

			For State Registrar	State of Maryla	•	rtificate of			Reg. N	1 1	108	3390
П	Physici		1. Decedent's Name (First, Middle, Las Irene Owens Thomp					2. Date of De Month DECEM	D	ay	Year 200	3. Time of Death 8 02:52PM
- Salar	/Medic Examir		4a. Facility Name (If not institution, give Saint Joseph	e street and number)	nter	4b. City, Town, o	r Location of Death	1			of Death	
	Funeral Director		5. Social Security Number 6. S Urik • 1	ex 7. Age ( <i>In yrs</i>	. last birthday) Yrs.	If Under 1 Year   Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di Jan • 01	rth ay, Year	16	9. Birth Cou WOT	place (State or Foreign intry) Chville, N.C
	ס		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
	Marylaria sho	tor		re County	Luther	cville-Ti	monium					1 □Yes 2 HNo
	th with the 23a or 28 ist be not	al Dire	10e. Street and Number 2218 Dalewood Roa	d		10f. Zip Code	1093				What Cou ed St	_{intry?} tates
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examiner must be notified at injury or other traumatic.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	-	Was Decedent of H If Yes, specify Cub 1 □Yes 2≦No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0-		ck, White,	ican Indian, etc. White
15-(	n 72 h	lete	15. Decedent's Ed (Specify only highest gra		16a. Dece (Give	edent's Usual Occup kind of work done DO NOT use retire	pation during most of wor d)	king	16b.	Kind of Bu	usiness/Ir	ndustry
212	d withingiene.	Comp	Elementary/Secondary (0-12)	College (1-4or 5+) N/A		surance A				II	nsura	ance
Maryland	S should be filed withi and Mental Hygiene. Is marked other than aumatic event, the Man	To Be (	17. Father's Name (First, Middle, Last) Robert Marvin Owe				18. Mother's Nan Mattie F				1e)	
	and 2 sho ealth and I n 27 Is ma ier trauma		19a. Informant's Name/Relationship ( Mr.Alson Gray Tho	mpson, Jr. (Son	) 2218	B Dalewoo			/ill	e-Ti	morii	.m.,MD 21093
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Inc. M. PDE.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State 1777	Place of Dispo cemetery, cre ans Fur	osition (Name of matory or other pla neral Cha	pel A	3 08				own, State l, Maryland
Baft	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	f- gar	7 h Pe	2. Name and Addr eaceful A 2325 York	is of Facility Iternativ Road I	res Fund Timonium	eral n,Ma	&Crei	natio	on Ctr.,P.A 21093
П			23a. Party Enter the disease or com shock, or heart failure. List only	plications that calvsed the dea one cause on each line.	ath. Do not en	iter the mode of dy	ng, such as cardiad	or respiratory a	arrest,			Approximate Interval Between Onset and Death
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. REŚPIRAT  Due to (or as a conse		AILURE						
	Examiner	_	Sequentially list conditions.	b. FNEUMONI	A							
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):							
68760,	rificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):							
	ertificating phy	Medical	IF FEMALE:	u								
.O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician//	23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 D No 9 ☐ Unknown	23c. If yes, outcome of preging 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	☐ Ectopic pregnan☐ Other (specify) _	су				ate of delive	very Day Year
ds, P.	uires that n signed b ld be deta	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	underlying cause gi	ven in Part I.			use cont		the cause of death?
Records,	: The law require cate has been signage 2 should b	Completed							psy ormed?		prior to co death?	opsy findings available ompletion of cause of
of Vital	hysician: The his certificate I director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Dea	1 ∐Yes ath (Check only	one)	10	1 🗆 Yes	2 <b>X</b> No
of V	Phys this al dii	2	1 Yes 2 No  27. Manner of Death	Hospital: 1 Inpatient 2 [ 28a. Date of Injury	ER/Outpatie	III 3 LI DOA		lome 5 Res				ify)
ion	Attending Ph ir death. ector: After th by the funeral	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Wo	rk? ]Yes 2□No	20d. Describe	now my	ary occurr	Tod	
Division	al or Atte s after de il Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location City or To	(Street a wn, Sta	and Numb te)	per or Ru	ral Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (		nysician: To the best of my kr niner; On the basis of examin and manner stated.								
	To the vithin comp	Ž	29b. Signature and title of certifie	- La MI	)	29c. Licen			29d. C	ate signe	d (Month	, Day, Year)
	. 5		30. Name and address of person who	completed cause of death (the	// em 23a) (Type		4034		l	4	4	10
	Q U		TIMOTHY LOW.	M. D. A. 76/11	GSLER	DOLUE	TOWSON.	MARYLO	dMb	212	1214	
	Sta Registi		31. Date filed (Month, Day Year) 20	32 Registrar's Sign	ature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryla		partment of I Certificate of			giene Reg. No. 200	3 33902
	Physici	an	<ol> <li>Decedent's Name (First, Middle, La Mary Jane Tummine</li> </ol>	*				2. Date of Dea Month	Day Ye	3. Time of Death
	/Medic		4a. Facility Name (If not institution, giv			4h City Town	or Location of Death		er 03,2008	
, de	Examin	er	Gilchrist Hospic				rowson	ı		re County
	Funeral		Social Security Number     6. S	Sex 7. Age (In yr		ay) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9.1	Birthplace (State or Foreign Country)
	Director		219-10-1589 Usual Residence of Decedent	1□M 24国F   8:	2 Yrs			March 1	3,1926 Ba	ltimore, MD.
	yland yland		10a. State 10b. County	10c. (	City, Town or	Location				10d. Inside City Limits
	Ba-fsl	ctor	Maryland Baltimo:	re County I	Luther	ville				1 □Yes 2X No
	vith th	Funeral Directo	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of What	Country?
	eath v	eral	1547 Pickett Road	12. Was Decedent Ever in	110 1		21093	a a if . Va a a v N a	United	
036	be filed within 72 hours after death with the Maryland the Wighen. Indepth than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, I'm Modral Evan har must be notified at	ρλ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	0.3.	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No	an, Mexican, Puerto	o Rican, etc.)	Specify:	merican Indian, hite, etc. White
2-0036	72 hor	eted	15. Decedent's Ec (Specify only highest gra	lducation	16a. De	ecedent's Usual Occupive kind of work done	pation	vina	16b. Kind of Busine	ss/Industry
7	within 72 iene. than "na	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ive kind of work done e. DO NOT use retire		uiig		
7 0	filed v Hygie	ပိ	17. Father's Name (First, Middle, Last)	n/a		Home Mak		ne (First, Middle, I	OWN Maiden Surname)	Home
yland	Aental Aental rked o	To Be	Lawrence Hooper				Ida Kins		,	
Mar	2 should be and Menta Is marked aumatic ev		19a. Informant's Name/Relationship (		19b. Ma	ailing Address (Street				
e, e	1 and 1 ealth 3m 27 ther tr		Mr. Dominic Joseph			7 Pickett			lle,Maryla	
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menti Important: If item 27 is marked any injury or other traumatic edonce.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif		orelan	sposition (Name of frematory or other place d Mem. Park	Dec.	05,	20c. Location - City Baltinore	e, Maryland
g	Depar Depar Impor any in		21. Signature of Funeral Service Licer	J. gan	2.	22. Name and Addre Peaceful A 2325 York	s of Facility Iternativ Road	res Fune: Timonium,	ral&Cremat ,Maryland	tion Ctr.P.A. 21093
	Physician /Medical Examiner		23a. Pan 1. Enter the disease, or compensation, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dea one cause on each line.  a	ath. Do not	enter the mode of dyi	ng, such as cardiac	or respiratory arm	est,	Approximate Interval Between Onset and Death MA 071 tys
,00,00	rificate be executed og physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last	C						
	ed for use	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1  Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of o	delivery Day Year
ר , ר	uires that signed b	d by Phy	Part II. Other significant conditions of	ontributing to death but not res	sulting in the	underlying cause giv	en in Part I.	23e. Did tot		to the cause of death?  Probably 4 Unknown
2	has been signed as 2 should be o	Completed						24a. Was ar	n 24b. Were	autopsy findings available
ב ב	nysician: The is his certificate ha I director, page 2	Be Com	25. Was case referred to medical				26. Place of Deat	autops perforn 1 □ Yes 2	ned? death 2 DaNo 1 □ Ye	o completion of cause of ? es 2 □ No
>	this ceral direc	B 2	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐	BR/Outpat	ient 3 DOA Oth				pecify) NOSPIG
	ath. r: After th		27. Manner of Death  1 ◯ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time Injury	y Worl	y at		w injury occurred	//
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		Medical	29a. Certifier (Check only one)  1, □ Certifying Ph 2 □ Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, de ation and/or	eath occurred at the tire investigation, in my o	me, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
,	with To t	Σ	29b. Signature and title of certifier			29c. Licens	e number	29	9d. Date signed (Mo	nth, Day, Year)
)	$\triangleleft$		year	M			0000	D	comber	3 700x
	'		77.900	LUES MO G	701 N	v. Chant	21 67 7	ONSON	MO ZI	204
	Stat Registra		31. Date filed (Month, Day, Year)  NFC 0 5 2008	32. Registrar's Sign	ature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 2^{Day}2008 **Physician** 4:50 P M Joan Lee Trent /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Somerford Place If Under 1 Year If Under 24 Hrs. Date of Birth Month, Pay, Year) June 11 1933 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 □ F Days Hours Months Baltimore, Maryland 75 216 34 3235 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 👿 No Ocean Pines Director Worchester Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 USA 14 Drawbridge Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 💢 No Specify: Specify: þ 3 KWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (4-4or 5+) Baltimore County Schools Guidance Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Calligan William Bankard ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health ar Important: If item 27 is any injury or other trau 8642 Toner Drive Laurel, Md. 20723 Barry C Trent (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gdns. December 5 2008 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign thre of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc Mother 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6 Months Immediate Cause (Final disease or condition resulting in death) Failure To Thrive Physician Due to (or as a consequence of): Alzheimer's Dementia 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Hyperlipidemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760, Division or Vital Records, P.O. been signed by the should be detached page 2 s After this certificate or Attending Physician: director funeral s after deau.
ral Director: Aftr filled in by within 24 hours a

To the Funeral I To the Hospital

Baltimore, Maryland 21215-0036

d 2 should be filed whand Mental Hygien is marked other the

Pages '

Certification: To Be Medical

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

(Check only one)

29b. Signature and five of certifier

6 ☐ Could not be determined

28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

DD047707

Laurel, Maryland 20707

12/2/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13621 Baltimore Avenue Rita Pabla MD

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

U

State Registrar

			1 - State of Ma Registrar Amend Item 1 per dr	ryland / Depa , g886 , 12/	artment of Health and 05/08dhb rtificate of Death	d Mental Hygi	ene g. No.2 1118	33901
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Larry		Tracey	2. Date of Death Month November	Day Year	3. Time of Death
1	Examir		4a. Facility Name (If not institution, give street and number)  Carroll Hospital Center		4b. City, Town, or Location of De Westminster		4c. County of Dear	
	Funeral Director		5. Social Security Number 216−66−8035 6. Sex 7. Age 54  Usual Residence of Decedent	(In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 F Months Days Hours M	lrs. 8. Date of Birth (Month, Day, June 24	9. Birt 1954	thplace (State or Foreign buntry) MD
	Maryland I show	tor	10a. State 10b. County  MD Carrol1	10c. City, Town or Lo Finksb				10d. Inside City Limits 1 □Yes 2 No
	h with the 23a or 28a st be noti	<b>Funeral Director</b>	10e. Street and Number 4028 Sykesville Road		10f. Zip Code 21048		g. Citizen of What Co JSA	puntry?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinar must be notified at		11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 □ Yes 2 □ N If Yes, Give A Year or Dates:	0	Uwas Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ∐Yes 2 ∰No <i>Specify</i> :	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
Baltimore, Maryland 21215-0036	d within 72 ho giene. Ir than "natur The Medical I	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+	(Give	dent's Usual Occupation kind of work done during most of v DO NOT use retired) .SCaper	vorking	6b. Kind of Business/	Industry
/land ?	be d c	To Be C	17. Father's Name (First, Middle, Last) James Franklin Tracey			Name (First, Middle, Ma Wilson	aiden Surname)	-
, Mar	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print) Denise S. Tracey (spouse)		ng Address (Street and Number or Sykesville Rd.,			Zip Code)
imore	Pages 1 Iment of H Iant: If iter		20a. Method of Disposition  14 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Bethesday		12-08 Sy	kesville,	MD
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee  Paricy Harght Sterlan		2. Name and Address of Facility Ha 2.0. Box 195 Syke			Chape1
	Physician /Medical Examiner		resulting in death)  oue to (or as a	consequence of):	er the mode of dying, such as card	liac or respiratory arres	it,	Approximate Interval Between Onset and Death 3
8/60,	ficate be executed physician and s the burial-transit	dical Examiner	day, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):				(100)00
. Box 6	death certi e attending d for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli Month	ivery Day Year
ecords, P	The law requires that the ate has been signed by thoage 2 should be detache	by	Part II. Other significant conditions contributing to death but	not resulting in the un	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ai neco	sician: The law re certificate has ber ector, page 2 sho	Completed				24a. Was an - autopsy performe 1 □ Yes 2	prior to c	topsy findings available completion of cause of
vision of vital	ng Phys fter this ineral di	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient  27. Man er of Death 1 Natural 5 Pending (Month, Day, 1) 2 Accident investigation	28b. Time of	t 3 DOA Other: 4 Nursing	eath (Check only one)  Home 5 Residence  28d. Describe how		cify)
SIN	to the hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Deviside 6 Devild not be -	y - At home, farm, stre (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
:	the Hospi hin 24 hour the Funer npletely fill	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	skallillalion and/or inv	occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the cau	se(s) and manner as and place, and due	stated. to the cause(s)
	0 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6		29b. Signature and title of certifier	10	29c. License number 00065045		Date signed Month	Day, Year)
				th (Item 23a) (Type, F	orini) orenest, Balt	mon, m	5 21201	
	Stat Registra		31. Date filed (Month, Day, Year) B2. Registrar's	s Signature	le le			

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dec. 1 2008 Patricia G. Travers 145 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2204 Monocacy Road Essex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 M 2 D Months Days 220-36-4786 67 Oct.20,1941 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State MD Baltimore Essex 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2204 Monocacy Road 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 □ No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Cintas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph P. Scalone Katherine M. Mayfort 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herman Travers /husband 2204 Monocacy Road Balto. MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【ICremation 3 ☐ Removal from State Bayview Crematory 12/3/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Paluk 2 Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi Division of Vital Records, P.O. Box 68760, physician the burial attending p for use as t been signed by the should be detached f icate has been ; page 2 should this certificate ours after death.

eral Director: After this certific filled in by the funeral director,

within 24 hours a

To the Funeral C

completely filled i

Completed

Physician

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Madical Examinating to notified at any injury or other traumatic event, If a Madical Examination in the notified at any once.

**Physician** /Medical

**Examiner** 

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

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Exami

Physician/Medical

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Be

Medical Certification: To 8

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific

determined

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Iphia ROAD BALTO. MD 9110. Bah HUZEA

31. Date filed (Month, Day, Year,

4 Homicide

29a. Certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year **Physician** Norman L. Trott 4:30 PM 12 2 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Square Hospital Center Rosedale Baltimore 8. Date of Birth (Month, Day, Year) Sept. 23, 1950 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 2M 2 ☐ F 214-56-5101 58 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits MD Baltimore Director Essex 1 □Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 850 Brunswick Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★JYes 2□No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 🕍 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10th College (1-4or 5+) Processor Gov. - Alliance permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If Item 27 Is marked other the any Injury or other traumatic event, the 1 once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin Trott Dorothy Scott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Sheila Lates /daughter 32 Helicopter Drive Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 12/5/08 5 ☐ Other (Specify) Baltimore MD 4 ☐ Donation 21. Signature of F wral Service 22. Name and Address of Facility 300 Mace Ave. Balto. MD alux Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a confequence of): cancer /Medical **Examiner** Tobacco abuse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Preumonia Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 □Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be

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death with the Maryland

Norman

21215-0036

Baltimore, Maryland

i Hygiene. other than "natural", or items 23a or 28a-f show

event, the Medical Examinan must be notified at

The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar s certificate has t irector, page 2 s

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State

Registrar

Certification: To 29a. Certifier Medical

(Check only one) 29b. Signature and title of certifier

determined

and manner stated.

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Balto md

065409

12-2-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

maria Carrillo FRANKLIN Square DR 9000

31. Date filed (Month, Day, Year) DEC 0 5 2008

4 Homicide

32. Registrar's Signature 3034 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#26per VERB, G886, 12/5/08, WS State of Maryland/ Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 2008 December 4:30 a M Elizabeth Catherine Terwilliger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Edgewood Tender Loving Care Assisted Living 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Min. Months Days Hours JAN 21 1919 216-12-3786 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, in a Medical Examination to retified all Director 1 ☐ Yes 2 No Bel Air MD Harford with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 USA 1336 Vanderbilt Road death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2**X** No Specify. 2 Specify: White 3 Midowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than * Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Englebrecht Schleigh other traumatic ပ 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau once. Karl A. Terwilliger - son 1336 Vanderbilt Road, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Metro Crematory, Inc. 12/02/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Leven H. Williams ²Cremation Society of Maryland, Inc. - Huli 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ALZHEIMER S DEMENTIN Z YRS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duvito for es a consecuence offi signed by the attending physician and deelached for use as the burial-trar Due to (or as a consequence of) certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 \subseteq Ectopic pregnancy page 2 should be detached for Month Vear Dav 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? MACULAR DEGENERATION 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed DIABETE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate HYPERITENS 1 ☐ Yes 2 ☐ No Ž√Z No Physician: 25. Was case referred to medical examiner?
1 Yes 2 No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 3 Hestdence 6 Other (Specify Living Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59805 12/03/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Baltimore, Maryland 21215-0036

 $\#\mathcal{H}_{\alpha} \# / 0e^{-4} \mathcal{I}_{c}$ Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ALICE LEE

31. Date filed (Month, Day, Year)

32. Registrar's Signature

4924 CAMBBELL BOULEVARD SOTTE 200 BALTIMORE MD 21236

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Director; / 1 24 hours a within 2

27. Manner of Feath 1 Natural 2 ☐ Accident	5 Pending investigation	28a, Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	e how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location City or To	(Street and Number or Rural Route Number, own, State)
29a. Certifler (Check only one)	Certifying Physi	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occurrention and/or investigation	ed at the time, date and plac ion, in my opinion, death occ	ce, and due to the	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
29b. Signature and		anno	MD	29c. License number D201	08	29d. Date signed (Month, Day, Year)
RAICES	ss of person who com	npleted cause of death (Iten	1 23a) (Type, Print) 1 0 0 GA	CLANTFO	KLN,	222 BOWIEM020710

State Registrar

Medical

31. Date filed (Month, Day, Year)

DFC 0 5

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 220110 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Year av 10:30A M 02 /Medical 2001 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospital tarbor Baltimore n/a If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | OCt. 12, 1931 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign N. Carolina 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Months 243 38 6034 77 Director Usual Residence of Decedent 10b. County 10a State 28a-f show 10c. City. Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at MD n/a Baltimore Director 1¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or filed within 72 hours after death with 901 Cherry Hill Rd 21225 USA Funeral items. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☑ Never Married 2 ☐ Married 10 Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: ð Specify: black 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10th Inspection/checker Plastic Company 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Herman Taylor Margie McKinlev ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troone. Deborah Worrell/niece 2916 Carver Rd. Balto, Md. 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) Mt. Zion Cem. Dec. 6,2008 Balto, Md. gnature of Funeral Service Licens ²². Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Despirator disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be execute burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autops, performed: 2/Q No certificate 1 □ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🕅 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral Manner of Death 28a. Date of Injury 28b. Time of After 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) es001 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) 140BING South Baltimore, 3001 Hanover

Registrar

State

31. Date filed (Month, Day,

Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Robert Vaugnan	B	Amend It			88, 12p	artment c 05/08dh ertificate	T Health an Death	id Mentai		Reg. No	08 3891
Physician Medical Examine		1. Decedent's Name Robe:		st) <b>ghan</b>					2. Date of De Month November	path Day Year er 26, 2008	3. Time of Death 1955 hrs
	4	4a Facility Name (r Franklin Sq		ve street and nur	mber)		4b. City, Town, o Rosedale	r Location of De		4c. County of Baltimore	
Funeral Director	- 1	5. Social Security N 218-84-52		ex M 2 F	7. Age (In yrs. <b>39</b>	last birthday) Yı	If Under 1 Yea  Months Day s.	<del></del>		/1969	Birthplace (State or Foroign Country)
d e. e.	-	Usual Residence of 10a State MD	Decedent 10b. County Baltimo	ore	^	y, Town or Loca	ition				10d Inside City Limits 1 Yes 2 XNo
and with the Maryland items 23a or 28a-f show ust be notified at once.	Discion	10e Street and Nu			La .		10f. Zip Code <b>21221</b>			10g Citizen of Wha	at Country?
ិខ្លុំ ៦៩ ជ		3 Widowed		d Armed For 1 Yes d If Yes, Give Year or Dates:	2 X No	1	as Decedent of Hi Yes, specify Cuba	in, <b>M</b> exican, Pue o s <i>pecify:</i>	erto Rican, etc.)	White, Specify	White
Fe, MD 21215-0036 St. I and 2 should be filed within 72 hours after the stand Mental Hygiene If item 27 is marked other than "natural", her traumatic event, the Medical Examiner	nalaidur	15 Decedent's Ed Elementary/Seco 12th	ondary (0-12)	College (1		- during i	ent's Usual Occupa most of working life			16b. Kind of Bus	uction
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygier han Important: If item 27 is marked other than injury or other traumatic event, the Medical To De Commerce.	2		l Vaughan	ı L				Mary	L. John		
MD 2 2 shoul th and M 27 is m	2	19a. Informant's Na Raymond	Vaughan		er					umber, City or Town	
nore, I			X Cremation 3		om State	crematory or o	osition (Name of co other place) Crematory		Date 2/02/08		City or Town, State
Baltin permit P Departme Importan	L.	4 Donation 5 21 Signature of Fu  Patrick		nsee	per dvr	22.	Name and Addres	ss of Facility Co	onnelly	Funeral H MD 21221	ore, MD ome of Essex
Physician /Medical Examiner			ly one cause on e Final disease a	each line. Probabl	e drug	th. Do not enter		g, such as cardia	ac or respiratory a	rrest, shock, or hea	Approximate Interval Between Onset and Death
ted Instit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde (Disease or injury to events resulting in	nmediate erlying Cause that initiated death) Last	Due to (or as a							
execui	edicai	X UNPENDED		AMENDED	23a,27	,28a-f,	perME,	G886 12	/11/08 T	T	
ox 6876 eath certificat attending phy for use as the	Sician/iv	IF FEMALE: 23b. Was decedent past 12 months 1 Yes 2	5?	1 Live b	ant at time of o	2 F	etal death 3 Other (Specify)	Ectopic pre	egnancy	23d Date of o	delivery Day Year
ords, P.O. B  wrequires that the d s been signed by the should be detached	6	Part II. Other sign	ificant conditions	contributing to	death but not	resulting in the	underlying cause	given in Part I			pute to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. Io the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Interfor: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed									opsy proformed? de	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
Vital hysician:	o Re	<ul><li>25. Was case reference</li><li>examiner?</li><li>1 ✓ Yes</li></ul>	red to medical	Hospital: 1 I	Inpatient 2	✓ ER/Outpatie		Other Nu	eck only one) ursing Home 5	Residence 6	Other:
on of Nature of It.	- t	27. Manner of Dea		28a. Date (Month		28b. Time o	1	ury at Work? Yes 2 X No	28d. Describ	e how injury occurre	ed
Divisior piral or Attend ours after death eral Director: filled in by the	Certification:	Accident  Suicide  Homicide	6 X Could no determin	28e Plac	e of Injuny - At	home farm str iver Ne n Ave.	pm eet, factory, office ck Rd &	building, etc.	28f Location or Town	State)	r or Rural Route Number, City River, MD
To the Hos within 24 h To the Fun completely		29a. Certifier 1 (Check only one) 2		er: On the basis	of examination					use(s) and manner te and place, and do	
To To Cor	Mec	29b. Signature and	title of certifier	and manner s	stated.	<u> </u>	1	.M.E.		29d Date signe	ed (Month, Day, Year) 29, 2008
		30. Name and add Jack Titus I	. /	completed cause Chief Medic		,	enn Street, Ba	altimore, MD	21201		
Sta Registr	te	31. Date filed (Mor	"0 5 2008	32. Re	egistrar's Signa	ature					

			State of Maryland / Depar	tment of Health and M <i>ificate of Death</i>	, ,	13 13 12 15	
			1. Decedent's Name (First, Middle, Last)	nicale of Dealif	Reg. 2. Date of Death	No.	3. Time of Death
	Physici /Medic		KATHRYN BRIDGET WHITMAN			Day 2008	10:00 PM
	Examin		4a. Facility Name (If not institution, give street and number)  NATIONAL NAVAL MEDICAL CENTER	4b. City, Town, or Location of Death BETHESDA		4c. County of Death	4EDV
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	MONTGOM 9. Birthpl	IERY lace (State or Foreign try)
ŀ	Director		None Yrs.	Months Days Hours Min.	Nov. 21,	2008 Mary	land
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Local	tion		10	Od. Inside City Limits
	a-fsh	ctor	Maryland Montgomery Silver Spi	ring			1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number	10f. Zip Code		Citizen of What Count	iry?
	eath w	Funeral	1700 White Oak Drive  11. Marital Status	20190		J.S.A.	on Indian
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show acal Ever it the rolls of a		1 🖾 Never Married 2 □ Married   1 □ Yes 2 🛣 No	as Decedent of Hispanic Origin? (Spi es, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	
21215-0036	ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	☐Yes 2X☐No <i>Specify:</i>		Specify: Whi	
15-	in 72 h n "nati	Completed	(Specify only highest grade completed) (Give kir	nt's Usual Occupation nd of work done during most of worki ONOT use retired)	ing 16b	. Kind of Business/Ind	ustry
212	d with giene, er thai	Je m	Elementary/Secondary (0-12)   College (1-4or 5+)	/A	N/	A	
and	be file Ital Hy Id oth	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	den Surname)	
Maryland	hould of Mer marke matic	၀	Timothy Whitman  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing	Mandy Fi		tu de Toure State Zin	Code
ĭ Za	alth ar 27 is sr trau			hite Oak Dr., Sil			,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventure roust be notified at once.		20a. Method of Disposition 1 ☒ Burial ⊋ ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cremater.	on (Name of Etory or other place)	Date 20c	Location - City or Tov	vn, State
III.	it. Pag rtmeni rtant: njury e	H	4 □ Donation 5 □ Other (Specify) St. Mary's			ir Haven,	VT
Ba	Depa Impo any i			Name and Address of Facility allory Funeral Ho		T/T 057/2	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	S. Park P1., Fai the mode of dying, such as cardiac			Approximate Interval Between
E	Physician		Immediate Cause (Final disease or condition COMPLICATIONS OF	TRISOMY 18			Onset and Death
-	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
	7 +	Jer	Sequentially list conditions, it any leading to immediate the cause. Extend I long-things.				
	ecuted and -transit	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C				
68760,	ificate be executed physician and is the burial-transit	ia E	Due to (or as a consequence of):				
		ledical	d				
Box	The law requires that the death certifi ste has been signed by the attending sage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ E	ctopic pregnancy		23d. Date of deliver	,
o	the de	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day Year
ري ص	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
ğ	equire sen sig ould b				1 ☐ Yes	2 <b>X</b> ] No 3 ☐ Proba	ably 4 🗌 Unknown
Division of Vital Records,	e law r has be	Completed			24a. Was an autopsy	prior to com	esy findings available appletion of cause of
ā			25. Was case referred to medical		performed 1 ☐ Yes 2 😾		2 □No
Ž	Attending Physician: r death. ector: After this certifics by the funeral director, p	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient	26. Place of Death 3 □ DOA Other: 4 □ Nursing Hor		6 ☐ Other (Specify	)
0	ng Ph vfter th uneral	on: T	27. Manner of Death 1 ☑ Natural 5 □ Pending (Month, Day, Year)  28a. Date of Injury (Month, Day, Year)		28d. Describe how in		
<u>sio</u>	ttendi death. stor: A / the fu	icati	2 Accident investigation 3 Suicide 6 Could not be 380 Place of Injury. At home farm street	M 1 Tyes 2 No	206 Location (Otro-		O
2	al or A s after I Direct	Certification:	4 ☐ Homicide determined building, etc. (Specify)	, lactory, office	City or Town, St	and Number or Rural ate)	noute Number,
			29a. Certifier (Check only   Check curred at the time, date and place,	and due to the cause	e(s) and manner as sta	ated.	
	the Fithin 24 the Fithin 24 the Fithin 24 the Fithin 24 the Fithin 24 the Fithin 24 the Fithin 24 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 the Fithin 34 th	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number			
	F ≥ F 28		micale R. Dalsa, Mo			Date signed (Month, D $1/26/08$	uy, roarj
	<u> </u>	ŀ	30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	25MA07382700 NATIONAL N	(/		
	l		NICOLE R. DOBSON MAJ MC USA	BETHESDA M	D 20889-5	600	
	Stat Registra		31. Date filed (Month, Day, Year)  DEC 0 5 2008  32. Registrar's Signature				,

			1 - For Stete Registrar	tate of Mai	ryland / Dep <i>Ce</i>	artmen			and M	lental Hy	giene Reg. No.	008	38912
	Div		Decedent's Name (First, Middle, Last)							2. Date of De	ath	Vone	3. Time of Death
	Physici /Medio		Mary Agnes Weaver							Decemb	er 3	<b>,</b> 2008	6:20AM
}	Examir		4a. Facility Name (If not institution, give stre	et and number)				Location of	of Death		4c. (	County of Dea	ath
			Ester Place			Balt			24 Hrs.				
	Funeral Director		5. Social Security Number 218–18–6649 6. Sex 1 □ M	2 TF	(In yrs. last birthday 84 Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da 08/26/	Year)	C	rthplace (State or Foreign country) rvland
			Usual Residence of Decedent		01	1				00/20/	1224	l'ia.	Lytana
	yland		10a. State · 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits
	e Ma	cto	Maryland Baltimore		Middle 1	River							1 ☐ Yes 2 XNo
	ith th	Dire	10e. Street and Number	_ ,		10f. Zip						en of What C	ountry?
	s 23e	by Funeral Director	12937 Cunninghill Co				220		. 0 /0			5.A.	
	Item Item	-un-		Was Decedent Ev Armed Forces? 1 ∐Yes 2 ⊠No	ver in U.S. 13.	If Yes, spec	ify Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	)- 1	4. Race - Am Black, Whi	
936	urs af	by F	-	If Yes, Give Year or Dates:		1 ☐ Yes 2	2⊠ No	Specify:			5	Specify: Wh	nite
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show he Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade co	on malatad)	16a. Dece	edent's Usua kind of wor	I Occupa	ation	t of worki		16b. Kin	d of Business	s/Industry
21	ithin 7	nple		College (1-4or 5+)	) life.	DO NOT us	e retired,	)	t of worki	ng			
	led w lygier lygier her th		11		Book	Keepe	er	40.14.4	1. 11.	/E:			t Store
and	ntal H	Be	17. Father's Name (First, Middle, Last)  John Hayward							(First, Middle, skell	, Maiden S	iumame)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Medical Examinar must be notified at	은	19a. Informant's Name/Relationship (Type,	Print)	19h Mail	ing Address	(Street a			l Route Numb	er City or	Town State	Zin Code)
Ma	and 2 sealth an n 27 is		Bonnie Petajnik (Dau	-									Md. 21220
ē,	s 1 and 2 f Health item 27 a		20a. Method of Disposition		20b. Place of Disp cemetery, cre					ate		ation - City or	
Ë	Page:		12 Surial 2 ☐ Cremation 3 ☐ Reme 3 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	Parkwood				12/05	5/2008	Balti	more,	Maryland
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is eny injury or other treu		21. Signature of Financial Service Licensee		2	2. Name and	d Addres			Funera			
<u> </u>	89888		1-1-1-		>	1407 C	ld E	laste	rn Av	renue,	Essex	Mary	land 21221
			23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	ons that caused that ause on each line	he death. Do not en	ter the mode	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease r condition resulting in death)	Pre	umane	-O~							Onset and Death
	/Medical Examiner		resulting in dealin)	_	consequence of);								3 00=0
		آة.	Sequentially list conditions, if any, leading to immediate	-	consequence of):	~							sgrs
	uted 3 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	,									
oʻ	exection and and rial-tra	Exa	resulting in death) Last	Due to (or as a	consequence of);								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d										
9	death certifica attending ph	Med	IF FEMALE:										50
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of 1□Live birth 2	Fetal death 3	Ectopic pre					23	3d. Date of de Month	livery Day Year
	he de the a	ysic	1 ☐ Yes 2 M No	4□Pregnant at tir 9□Unknown	me of death 5 [	Other (spe	əcify)						,
P.0	res that the d igned by the be detached		Part II. Other significant conditions contrib	uting to death but	not resulting in the t	ınderlying ca	use give	n in Part I.		23e. Did t	obacco us	e contribute t	o the cause of death?
rds	quires n sigr ald be	d by	COPD, C	2501	ary A	rter	1	) دور	ote	10	Yes 2□	No 3□P	robably 4 Unknown
00	s been s	olete	4		<i>-</i>		,			24a. Was		24b. Were a	utopsy findings available
of Vital Records,	The lav	Completed								autor perfo	osy ormed? 2000No	prior to death?	completion of cause of
ita	ysicien: The is certificate hadinector, page	BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o	~	, , ,	Estharte
× ×	Physic this ce al dire	일	1 ☐ Yes 2 No Hosp	1 Linpatient				4 LI NU	rsing Hor	ne 5 🗆 Resid	dence 6	ther (Spe	ocity) Place
	ding P	lon	1 Natural 5 Pending	8a. Date of Injury (Month, Day )	Year) 28b. Time o		3c. Injury Work			28d. Describe h	how injury	occurred	Ascested
Division	or Attendii after death. Director: A in by the fu	icat	Accident investigation  3 Suicide 6 Could not be	So Place of Injury	y - At home, farm, st	M root factory		'es 2 □ 1	-	98f Location (	Stroot and	Number or P	ural Route Number.
Ď	lor A after Direct	Certification	4 Homicide determined 2	building, etc.	(Specify)	ieet, iactory,	, once			City or Tov		reamber of th	arar House Ivaniber,
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifics completely filled in by the funeral director, it		29a. Certifier 1 Certifying Physicie	n: To the best of	my knowledge, deal	h occurred a	at the tim	e, date and	d place, a	ind due to the	cause(s) a	and manner a	s stated.
	n 24 h	edical	(Check only 2   Medical Examiner:	On the basis of ea and manner state	xamination and/or in	vestigation,	in my op	inion, deat	th occurre	ed at the time,	date and p	lace, and due	e to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier			29c.	License						h, Day, Year)
	1		moutes h	inely	8		D	45-	15	7	De	_ 3,	2005
	6		30. Name and address of person who compl  Motthew Mc	Nabres	4940	960	ster	n A	æ	Bult	7 ~or	e, MG	21224
	Sta Registr		DEC 0 5 2008	32. Registrar	s Stanature	E)							

			1 - For State Registrar	State of Mar	yland / De	epartmen Pertificat	t of H e <i>of L</i>	ealth a Death	and M		iene () eg. No.	08	38913
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Louis J. Walters							2. Date of Dea Month	Day	Year 5 2008	3. Time of Death
	Examir Funeral Director		4a. Facility Neme (If not institution, give street)  5. Social Security Number  6. Sex  1 \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \) \( \)	tan Ho	in Vrs. last birtho	(funder Months	tin	Location of	of Death	8. Date of Birth (Month, Day September	4c. Count	y of Death  imore (	
· And And And And And And And And And And	D	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore		oc. City, Town o	or Location				oepoenbe.	. 30 132		Od. Inside City Limits  1 ☐ Yes 2 ☐ No
	Sa or 28a-	Funeral Director	10e. Street and Number 7810 West Moreland Aven	ue	Darchior	10f. Zip	Code 1234			1	0g. Citizen of USA		
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23a or 28a-f show aumatic event, the Mudical Examinar must be notified at	by	11. Marital Status 12.  1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Eve Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	erin U.S.	13. Was Deced If Yes, spec	offy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		ce - Americ ack, White, of	
Maryland 21215-0036	od within 72 hogiene. er then "netu	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 12	ion ompleted) College (1-4or 5+) 4	(C)	ecedent's Usua Give kind of wor fe. DO NOT us hanical	rk done d se retired)	uring most	of workir	ng	16b. Kind of E	Business/Inc	,
yland	should be file and Mental Hy marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last)  John Walters					Mary	Sbec	(First, Middle, M	Maiden Suma	me)	
	りゃくき		19a. Informant's Name/Relationship (Type, Ronald J Walters (Son)		40	8 Overlo	ok Dri		Lusby	/ Route Number /, Marylar	nd 20657		
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1XX Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)  21. □ True of Funeral Service-Licensee		20b. Place of D cemetery, Cheitenh	am Vetera	ans Ce	m. De	ec. 9	2008	20c. Location Upper Ma		
eg T	Departi Departi Importi eny inj		23a. Part1. Enter the disease, or complicat	ions that caused th	e death. Do not		Belair	Road	Ba]	Ltimore, M	aryland	21236	Approximate
	Physician /Medical Examiner		shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	clerst	.1				i) island			Interval Between Onset and Death
8/00,	death certificate be executed eathending physician and red for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a c								(desired)	
O. Box 6	death certi e attending od for use a	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of 1 Live birth 2 [4 Pregnant at tim 9 Unknown	Fetal death	3 □Ectopic pro						ite of deliver	ry Day Year
cords, r	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions contrib	outing to death but r	not resulting in th	e underlying ca	ause givei	n in Part I.			acco use con	tribute to the	e cause of death?
T T	The law ate has b page 2 sl	e Completed	25. Was case referred to medical						_		led?	prior to con death?	sy findings available ptetion of cause of
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician 11 26 2008 12:30 AMM <u>Arlene May Weir</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bel Air, Maryland Harford Bel Air Health & Rehabilitation Ctr If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕱 F Director 179-14-9513 06/26/1922 Pennsylvania Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Harford MD Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21078 Funerai 1122 Chesapeake Drive - Apt. 11C 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify. 3 X Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife & Day Care Provider DAy Care Industry 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie Fleisher ဥ Gruver Ruth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trat once. 21035 Geoffrey D. Weir 1010 Rosemont Drive - Joppa, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 11/28/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** con oscleratic Cardiovascular disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and that initiated events resulting in death) Last as a consequence of) that the death certificate be exe Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pre§nant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has Vital 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient Division or 27. M. nur of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director; / 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral E Hospital 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed Month, Day, Year) ess of berson who completed cause of death (Item 23a) (Type, Print) Havre de Grace 31. Date filed (Month, Day, Year) DEC 0 5 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 15, 2008 5:30 АМ м Gregory Wilson 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Future Care Homewood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea Jan 13, 1 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months 1 M 2 □ F Maryland 47 212-84-2191 1961 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1♥ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 633 N. Aisquith Street #17L 21202 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) 0 painter home improvements 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie Wilson Betty Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Williams/mother 633 N. Aisquith Street #17L Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other (Specify) in state 21. Signature of Euneral 8 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street SH Baltimore, MD 21201 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Archived Due to (owns a consequence of): Due to fur as a consequence off Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⚠ nknown 24a. Was an Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes performed 2 ☐ No 1∐ Yes 2 12 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuel of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury

**Physician** /Medical Examiner

law requires that the death certificate be executed

the

certificate has

After this

after death

within 24 hours a To the Funeral C

funeral director,

Hospital or Attending Physician:

Completed by

Be

Certification: To

Physician

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

and Mental Hygiene.

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other tt any Injury or other traumatic event, the once.

Director

Funeral

Completed by

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be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

6 Could not be determined

25. Was case referred to medical examiner? 1 Tes

> 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 W MOVNT

and manner stated.

31. Date filed (Month, Day,

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>5</u> **Physician** November 2008 Severn Whitehead 9:35 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Berlin Nursing & Rehab Center Berlin Worcester 8. Date of Birth (Month, Day, Nov 7, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. Maryland 1 M 2 □ F 76 22-28-0660 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. m 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD Worcester Pocomoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21851 P.O. Box 782 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white If Yes, Give Year or Dates: \$52-53 Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 6 heavy equipment operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Severn Whitehead Sr Tennis Bowden 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Denise Stewart/daughter 169 Kneece Mill Road BAtesburg, SC 29006 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signalure of Funeral Ser State Anatomy Board Baltimore, MD 21201 Ronald 655 W. Baltimore Street 23a. Part | Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVO Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner festive Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (dr as a consequence of): Examiner Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnan 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 1□ Yes 🔎 No 2 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 63199 30, Name a d d ress of person who completed cause of death (Item 23a) (Type, Print) YOG SH VOHRA 619 EASTERN SHO SALISBURY MD. DR. 425-201 614 EASTERN SHORE

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 0 5 2008

iiteHead, Severn Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

or Attending Physician;

Hospital

Division or Vital Records, P.O. Box 68760.

32. Registrar's Signature

			For State	State of Ma	ryland		ertment of l			lental Hy	177	nna	38917		
			Registrar  1. Decedent's Name (First, Middle, Las	st)			Timeate of	Dear		2. Date of De	Reg. No.	000	3. Time of Death		
	Physici				יו חב					DECEMI		Year ZZZZZ			
	/Medic Examir												c. County of Death Baltimore		
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	pu »		Usual Residence of Decedent		10 01						,				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	ρ	Maryland Baltimore		10c. City	, Town or L די	ocation DWSON					1	0d. Inside City Limits 1 ☐ Yes 2 📉 No		
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	12		30. Name and address of person who co	ompleted cause of dea	th (Item 2	23a) (Type,	Print)								

State Registrar

DEC 0 5 2008

RICHORD INTHICIM M.D. 7601
31. Date filed (Month, Day, Year) 32. Registrar's Signature OSLER DRIVE TOWSON, MARYLAND 21204

08-09062	
Margaret Wildberg	er
	1-
	Re

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 38918

	1- For State Registrar	Certificate of Death	, , ,	Reg. No.					
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)     Marg	garet Wildber	Decem	Day Year ber 2, 2008	3. Time of Death 0739 hrs				
e en en en en en en en en en en en en en	4a. Facility Name (if not institution, give street and number)  Franklin Square Hospital  4b. City, Town, or Location of Death  Rosedale  4c. County of Death  Baltimore Coun								
Funeral Director	5. Social Security Number 214-86-8351 6. Sex	7. Age (In yrs. last birthday) If Under Months  46 Yrs.	I See Little Little	of Birth (MM/DD/YYYY) 9. Bir ch 5,1962 Co					
Agyland Aaryland Laanse, Aaronce, eector	Usual Residence of Decedent  10a. State	10c. City, Town or Location	Middle River		10d. Inside City Limits  1 Yes 2 X No				
with the Maryland with the Maryland as 23a or 28a-f sho be notified at once aral Director	10e. Street and Number 116 Kingston Road	10f. Zip 0	21220	10g. Citizen of What Cour United Sta	•				
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5-0036 led within 72 hour Hygiene I other than "natu the Medical Exan Completed			18.Mother's Name (First, Mide Mary To	Federal Godle, Maiden Sumame) Duise Scott					
e, MD 21215-0036  1 and 2 should be filed within 7  Health and Mental Fygiene item 27 is marked other than r traumatic event, the Medical		19b. Mailing Address	(Street and Number or Rural Route S Green Circle		, Zip Code) nd 21221				
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Baltimo permit. Page Department o Important:	21. 5 gnal of Funeral Service Lipense	Duda-R 7922 V	ddress of Facility ack Funeral Home Vise Ave. Dundal	lk, Maryland 2	Inc. 21222				
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<u>.</u>	Sequentially list conditions.	s a consequence of): s a consequence of):							
Fxaminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s a consequence of):							
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To with To con	29b. Signature and title of certifier	29c.	License number  O.C.M.E. OCME	29d. Date signed (Mo					
$ \emptyset $	30. Name and address of person who completed of Theodore M. King, Jr., MD. Assis	Sese of death (Item 23a)	nn Street, Baltimore, MD 21						
State Registra	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	Stroot, Satisfiero, MD 21						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 Per FH G920 10/14/2011 III. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 6:49 PM M 2008 Michael Woodfolk December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 M 2 □ F 49 Director 12/25/1958 MD 212-76-8687 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar rust be notified at once. 1 ☐ Yes 2 ☑ No Director Baltimore MD Gwynn Oak 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 USA Funeral 3807 Bowers Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 No Yes, Give XX Never Married Vecember 1 2008 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No ģ Specify: 3 Widowed 4 Divorced Black Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Credit Rating Firm Elementary/Secondary (0-12) College (1-4or 5+) Collections Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Woodfolk Andrea Thomas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Robinson/Friend 6928 Digby Road Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Dec 4 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore. Approximate Interval Between Onset and Death 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Rend **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 □ No 3 Probably 4 ☐ Unknown Jood Kolk, Michael 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🕅 No 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) \( \text{Volume of Specify} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 № Natural

2 ☐ Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Escritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Occember 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles CT PONJIN ND ZIROY HAWES m 31/ Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene <table-cell> Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 1 Hoote when Days 2:15 AM Phyllis L. Wilfong /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner 4c. County of Death Baltimore Washington Medical Center Anne Arundel Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2 1 ¥ F Months Days Hours Min. 68 218 36 8662 Director 10/12/1940 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at Director 1 ☐ Yes 2 🗖 No Anne Arundel Glen Burnie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 456 Aventura Court 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Hygiene. other than "natural", or Maryland 21215-0036 1 ☐ Yes 2 A No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8th Homemaker Own Home Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, If once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be William Krampf Helen Marie Shoemaker ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence Wilfong / Husband 456 Aventura Court Glen Burnie, Maryland 21061 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/03/2008 Baltimore, Maryland Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. manucamon 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner il any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign be 1 ☐ Yes 2 ☐ No 3☐ Probably 4 🗖 Unknown Completed funeral director, page 2 should Physician: The law 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huspital Drive Glen Burnie,

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

DEC 0 5 2008

ang, PhyM

32. Registrar's Signature

08-09014 Judy Wright Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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D To the Hospital within 24 hours To the Funeral completely filled	g	4 Homicide  Check only one)  A Medical Examiner: On the basis of examination and/or investigation, in r	ne time, date and place, a	and due to the cause ed at the time, date a	ind place, and dae	
To To Com	Med		9c. License number O.C.M.E.		29d. Date signed December 1,	(Month, Day, Year)
4	-	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street,	Baltimore, MD 212	201		
St	tate	31. Date filed (Month), Day, Year) 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 30, Zear Wallace 111ton **Physician** 2159 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore City Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/07/1951 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Min 218-56-2310 57 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore MD 1 X Yes 2 ☐ No Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Heath and Mental Hygiene. Important: If flem 27 is marked other than "natural" ~ " any injury or other traumatic event "..." 21213 USA 1826 East North Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐XNo Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Labor Worker Elementary/Secondary (0-12) College (1-4 or 5+) Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doretha Mary Rouzer Wallace Joseph ည 19a. Informant's Name/Relationship (Type. Print)

Chantemonique Wallace / Daughter 9 West Elm Street, Overlea, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Ardent CremationServ. 12/05/2008 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
Po Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall Marsia oute (h 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5 days Due to (or as a consequence of) /Medical **Examiner** 5 days portane as Bacterial Sequentially list conditions, if any control of the cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of 10 physician and is the burial-transit or Attending Physician: The law requires that the death certificate be executed Years Hepatiti S Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) signed by the at ald be detached f 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 TYes 2 No 3 Probably 4 Unknown Completed is certificate has been si director, page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Mnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 No 3 DOA ၉ this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 Yes 2 No death. eral Director: A 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a

To the Funeral C

completely filled 1 KCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number medical RES-000 000+0R November 30,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rana Yehia, Johns Hapkins in Survey HOOK, NS HOSPITAL Rana Yehia, 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Year **Physician** John Robert Whipp December 9:32 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 7617 Daniels Avenue Baltimore 8. Date of Birth (Month, Day, Year) Jan 9, 1915 Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Min 1 X M 2 □ F Months Hours 93 Yrs Director 533-24-3075 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiens. International series against the Mental Hygien International States and Tale marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be redified at once. 1 Yes 2 ☐ No Director Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7617 Daniels Avenue 21234 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No 1936
If Yes, Give Year or Dates: 1944 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Repair Man Baltimore Gas & Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Robertshaw Whipp Mariquita McGrath 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7618 Daniels Avenue Baltimore, Maryland 21234 Barbara Novak, Friend 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Baltimore, Maryland Metro Crematory Inc. 12/03/08 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service (Lidensee ²², Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hemorrhage racranial dayo /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offiattending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the at d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Atheroscierosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Kidney Disease Chronic 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of perifier D 57444 December 2, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO BOX 19099, TOWSON, MO 21284 Alexander hen MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

DEC 0 5 2008

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Ramona Ann Zawo		y State of Maryland / Departm For State Certific			Mental Hy			
Physician/		egistrar . Decedent's Name (First, Middle,Last)		Douth		2. Date of Death	. No. 2	3 Time of Death
Medical Examine		Ramona Ann Zawodny			W., 110	Month December :		1518 hrs
( )	ľ	a. Facility Name (if not institution, give street and number) 7818 Old Harford Road	4	4b. City, Town, or L Parkville	ocation of Death		4c. County of Baltimore	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last bir	thday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth		9. Birthplace (State or
Director	I	217-78-8001 _{1 M 2 X F} 48		Months Days	Hours Min.	-	1	Foreign Country) MD
	-	Isual Residence of Decedent				.1		
ow any		Oa. State 10b. County 10c. City, Town Parkv						10d. Inside City Limits  1 Yes 2 No
yland a-f sho	3	0e. Street and Number		10f. Zip Code		100	g. Citizen of Wha	
death with the Maryland or items 23a or 28a-f show must be notified at once.		7818 Old Harford Road		21234			U.S.A.	•
r death with or items 23	2	1. Marital Status 1. Never Married 2 Married Armed Forces?		s Decedent of Hisp es, specify Cuban,			14. Race - White,	American Indian, Black, etc.
ter dea		1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year	1	Yes 2.X No	specify:		Specify:	White
ours after attural" tamine	3	I or Dates:	Deceden	t's Usual Occupation	on (Give kind of w		16b. Kind of Busi	
0036 within 72 hour giene. her than "natu Medical Exan		Elementary/Secondary (0-12) College (1-4 or 5+)	_	ost of working life. I 1Se Keep		ed)	Ripkin	n's Stadium
d within the the Med	<u></u>	7. Father's Name (First, Middle, Last)				(First, Middle, Ma	aiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica		Raymond Zawodny			wendoly	n Winerfir	ed Wile	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Re Compileted by Funeral Director				Address (Street B Old Ha				
re, l s l and f Healt ff item er tra	I			ition (Name of cem lineral	etery,	Date		City or Town, State
imo Page nent o			el-	Bel Air	- 1141	>/08		: Hill, MD
Baltimore, permit. Pages I an Department of Hee Important: If ite Important: If ite injury or other tr		1. Signature of Funeral Service Licensee	22. N	lame and Address of Une	rall chap	œl & Cre	nation	Services
Physician	1	3a/ Part I. Enter the disease, or complications that caused the death. Do n	ot enter th	00 Harfo ne mode of dying, s	uch as cardiac or	respiratory arres	MD 21 st, shock, or hear	
/Medical	ı	/ 'failure∬List only one cause on each line. mmediate Cause (Final disease a. <b>Cardiac Arrhyth</b>	mia					Between Onset and Death
	4	or condition resulting in death)  Due to (or as a consequence of):  Myocardial Fibr	neie					
iner		leny leading to immediate Due to (or as a consequence of):	OBIB					
nted d ansit Fxaminer		Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
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68760, errificate be eding physicia eas the buria		FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the	_				23d. Date of de	•
Box 68760 he death certificate be death certificate by the attending physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physical physic	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	past 12 months?	- =	tal death 3 L her (Specify)	Ectopic pregna	ncy	Month	Day <b>Ye</b> ar
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P.O. ss that the gned by e detach		art II. Other significant conditions contributing to death but not resulting	ig in the u	inderlying cause gi	ven in Part I.			ute to the cause of death?
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach		Chronic Alcohol Use				24a. Was ar		Probably 4 Unknown
of Vital Records,  ng Physician: The law require  Nher this certificate has been signered director, page 2 should b.	2					autops	y pri	ere autopsy findings available or to completion of cause of ath?
Rec The lifeate ; page	5					1 <b>✓</b> Yes 2		Yes 2 No
Vital Rec ysician: The his certificate director, page	3	5. Was case referred to medical examiner?  Hospital: Inpatient 2 ER/C	Outpatient	- Vo	of Death (Check of Dineral Nursin		Residence 6 🗸	Other: Scene
1 of Vii ting Physic After this funeral dir	t	7. Manner of Death 28a. Date of Injury 28b.	Time of I	2011	at Work?		ow injury occurred	
Sion of Artendin, death.  Stor: Algorithm of the fur		1 x Natural 5 Pending (Month, Day, Year)		1 Y	es 2 No			
Division o spiral or Attending rours after death. neral Director: After filled in by the fune Centification:		2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	arm, stree	et, factory, office bu	ilding, etc.	28f. Location (St or Town, Sta		or Rural Route Number, City
Lospita Hours Tumeral		9a. Certifier	ath occur	red at the time, dat	e and place and	due to the cause	(s) and manner a	s stated
Division of Vital Records, P.O. Box 6876  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours abred death.  To the Funcari Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the L. Medlical Certification: To Be Completed by Physician/Ma		ne) 2 Medical Examiner: On the basis of examination and/or and manner stated.		tion, in my opinion,	death occurred a	t the time, date a	nd place, and due	e to the cause(s)
E M		9b. Signature and title of certifier		29c. License O.C.M			29d. Date signed December 3	(Month, Day, Year)
S. S.	-	0. Name and address of person who completed cause of death (Item 23a)		0.0.1			December 3	, 2000
10		Donna M. Vincenti, MD Assistant Medical Examine		Penn Street,	Baltimore, M	D 21201		
State Registra	e Ir	1. Date filed (Month, Day, Year) 32. Registrar's Signature	acc	*				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month Vear **Physician** ZAHUK CHHK М MICHHEL NOVEMBER LOOS 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A HOPKINS BAYVEW MEDICAL CONFER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours PA. 198-38-0569 Director 2/7/1946 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No COLGATE MD. BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 UNITED STATES 7744 WYNBROOK ROAD Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 No Specify. <u></u> Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit, Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Mental and injury or other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CITY INVESTIGATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARGARET O'DONNELL DR. JOSEPH A. ZAHORCHAK ည 19a. Informant's Name/Relationship (Type. Print)
REBA ZAHORCHAK/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7744 WYNBROOK ROAD, BALTIMORE, MARYLAND 21224 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 12/04/2008 GLEN BURNIE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. Fun ral Service Licensee 21. Signature 6224 EASTERN AVE., BALTIMORE, MARYLAND 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK HOURS /Medical Due to (or as a consequence of): Examiner PERI TONITIS 24 HOURS BACTERIAL Sequentially list conditions, it they reading to infine diata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Examiner burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 NO 1 □Yes To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🖫 No 1 Inpatient 2 ER/Outpatient 3 DOA P filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AKWCIE MEDICAL DOCTOR 29, 200 8 RES-000 MOVEMBER

7

State Registrar EASTERN

AVENUE BALTIMORE MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) DEC 0 5 2008

4940

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $11/\overset{\text{Day}}{14}/200\overset{\text{Year}}{8}$ Month Physician Elvira Alcan 545 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Edgewater Anne Arundel South River Health & Rehab 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1/24/1942 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M **X**(**X**)F 212-17-1597 66 Yrs Panama Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Madical Examiner must be notified at Calvert North Beach 1 ☐ Yes XX No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3802 5th St. 238 20714 USA death Funeral items ; Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2KXNo Specify: White þ 3 Widowed 4XXDivorced "naturei", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home UNK UNK 17. Father's Name (First, Middle, Last) Department of Health and Mental Hy importent: if item 27 ie marked oth eny injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Alcan 3802 5th St. North Beach, MD 20714 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/18/2008 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Datas 12 Ridgely Ave. Annapolis, Md 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebrovosculas /Medical Examiner Condio vascular discosse Hthero Sclenutic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien a for use es the burial-Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hewit disease 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? in subbiciency 24a. Was an autopsy performed? Multi in Farct Dementio 1 ☐ Yes 2 ☐ No 1 Yes 2 🗗 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖢 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After s after de-rai Director: After hv the fv 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a

To the Funeral C

completely filled i Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) leyon.c 11-17-2008 D 50653 Surina GVAN .C. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deale Churchten Ruad Deale 31. Date filed (Month, NOV 1 8 2008 32. Kegistrar's Signature State Registrar

			1- State of Maryla Registrer		artment of Health and M tificate of Death	fental Hygien Reg. N	Z 11 11 16 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month NOV . 29	3. Time of Death				
	/Medic	cal	JUDITH LOUISE BYUS  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		2008 2:20P M				
	Examin	er	GENESIS LA PLATA CENTER		LA PLAT	ra c	HARLES				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yr. 1 M 2 XF	rs. (ast birthday) 67 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth FEB 3, 199	9. Birthplace (State or Foreign WASH., D.C.				
land	M III			City, Town or Lo			10d. Inside City Limits				
һө Мал	Sa-f sh cullied	ector	MD. CHARLES		LA PLATA		Yes 2 No				
h with ti	23a or 28a-f show uni be notified at	al Dir	10e. Street and Number #1 MAGNOLIA DRIVE		10f. Zip Code 20646	U.S	itizen of What Country? $lack A$ .				
G 21215-0036 filed within 72 hours atter death with the Maryland	al', or items ? Examiner mu	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE				
1215-0036 Aithin 72 hours af	ne. han "natur a Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	15. Decedent's Education (Specify only highest grade completed)  Identification (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Infection (Give kind of work done during most of working life. DO NOT use retired)							
	I Hygie other t	Be Co	11 th  17. Father's Name (First, Middle, Last)		CLERK  18. Mother's Name	e (First, Middle, Maide	RLES CONCRETE CO				
Maryland d 2 should be filt	th and Menta 7 is marked traumatic ev	ToE	JAMES WILLIAM WILSON	10h 14a ilia		JOYCE TH					
C	7 is		19a. Informant's Name/Relationship (Type, Print) ROBERT A. BYUS-SON		g Address (Street and Number or Run LOWER BRAMLEY						
Baltimore,	ment of Healt tant: If item 2 jury or other		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Place of Dispose cemetery, crem	sition (Name of natory or other place) ILL CEMETERY 12		Location - City or Town, State TLAND , MD .				
<b>Balt</b>	Department Important: any injury once.		21. Signature of Funeral Service Licensee MO0479	22	Name and Address of Facility RAYMOND FUNERAL LA DIATA MD 20	SERVICE	, P.A.				
П	nysician		23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	eath. Do not ente	LA PLATA, MD. 20 er the mode of dying, such as cardiac HEACT	or respiratory arrest,	Approximate Interval Between Onset and Death				
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48	ısı	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or/as a consequence of):							
cate be executed	physician and s the burial-transit	Examin	that initiated events c	equence of):							
	physici s the bu	dicai	d								
.O. BOX the the death certif	ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 🗌	Ectopic pregnancy		23d. Date of delivery Month Day Year				
ecords, P.O law requires that the	been signed t should be deta	þ	Part II. Other significant conditions contributing to death but not re	0			ouse contribute to the cause of death?  2 No 3 Probably 4 Unknown				
r E	ate h page	Completed	CHRUNIC Obstructive	= 7Wm	ONARY DIJISAS	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No				
OT VITAL Physicien: 1	is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	h (Check only one) me 5 ☐ Residence	6 Other (Specific)				
ION OT nding Phy	within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	28b. Time of		28d. Describe how inju					
DIVISION al or Attending	s after des	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At building, etc. (Special Coulding)	home, farm, stre	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number. te)				
• Hospit	24 hours • Funere letely fille	edicai (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kind one)  1 Medical Examiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the cause( red at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)				
To th	withir To th comp	Me	29b. Signature and fille of certifier		29c. License number	29d. D	late signed (Month, Day, Year)				
	3		30. Name and address of person who completed cause of death (Itt	tem 23a) (Type, I	Print) Inldact mil	201.00	100-100				
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 5 2008 32. Registrar's Sign	nature	2000 prod	2000-					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 17, 10:20 P M Myra Birch 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day. Months Days Hours 1 M 2 X F 78 07/05/1930 121-20-6309 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County VA Burke 1 □XYes 2 □ No Fairfax 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22015 USA 9009 Brook Ford Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: Specify. 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Garments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hyman Stone Mary Kaplan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9009 Brook Ford Road, Burke, Virginia Glen Birch, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☑ Removal from State New Montefiore Cemet. 11/21/2008 Pinelawn, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Facial Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mall disease or condition resulting in death) Due to (or as a consequence of) incisimal Dicar cerated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 movi 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of dea Advanced dimentia + dipression 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Ab. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 1□ Yes Other (Specify)

**Physician** /Medical **Examiner** 

and

The law requires that the death certificate be executed

Hospital or Attending Physician: 24 hours after death.

3

after death Director:

P.O. Box 68760,

**Physician** 

/Medical

Director

Funeral

δ

Completed

Be

Examiner

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

filled in by the funeral director, page 2 should be detach

Examiner Physician/Medical ģ Be Completed Certification: To To the Hospital c within 24 hours af To the Funeral D completely filled in

IF FEMALE: 23b. Was decedent pregnant

Was case referre examiner?		26. Place of Death (Check only one)										
 1 Yes 2	6	Hospital: 1 ☐ Inpatient 2	ER/Outpatient	3□[	OOA Other:	Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)					
Manner of Death 1 D Natural 2 Accident	5 Pending investigation		28b. Time of Injury	M	28c. Injury at Work?		28d. Describe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At	28e. Place of injury - At home, farm, street, building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Road, Rockville, MD 20852

Hebre Home Greak Walkington Roulile MD Zeba Shaheen Geloo

State Registrar

Medical

32 Registrar's Signature 31. Date filed (Month, Day, Year) 1 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2008 112RY BENSON 1:58 PM NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death **Examiner** PRINCE GEORGES CRESCENT CITYES CENTER RIVER DALE, If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🖫 F Director 87 578-22-5355 OCT. 13,1921 WASH. D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Eraminst must be notified at 10d. Inside City Limits Director 1√∑Yes 2 □ No PRINCE GEORGES COLLEGE PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8510 49th AVE. 20740 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify. 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wn Department of Health and Mental Hygien Important; If frem 27 is marked other that any injury or other traumatic exercises. ACCOUNTANT F.H.A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ CHARLES F. BENSON ALICE MARY WAT.SH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN LONG/NIECE 8510 49th AVE., COLLEGE PARK, MD. 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 11-21-2008 BRENTWOOD, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL 5801 CLEVELAND A ÄL HOME & CREMATORIUM,P.A. AVE., RIVERDALE, MD. 20737 400091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HEART FAILURE 10 MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner THEROSCLEDOTIC HEART DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 힏 in the past 12 months? 1 □ Yes 2 ☑ No Month Year Day signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ HY PER TENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ATRIAL FIBRILLATION HISTORY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 □ Yes 2 No 1 ☐Yes 2 ☐No 24 hours after death.
Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D. 25914 11-15-08 10 DR ALLEN BRIMMER, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIVERDALE, MARYLAND 20737

DHMH 17 Rev 1/2001

State

Registrar

4409

31. Date filed (Month, Day,

Year)

9 2008

EAST -

WEST

2. Registrar's Signature

HIGHWAT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jerome Irvin BAYLIN **Physician** 18, 2008 November 12:40 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville 5809 Nicholson Lane #1109 8. Date of Birth (Month, Day, Year) Sept. 13, 1930 Washington, DC If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F 78 Director 577-36-7234 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County ral", or items 23a or 28a-f show Examiner must be notified at Rockville 1 ☐ Yes 2 No Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 United States 5809 Nicholson Lane #1109 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Xyes 2 □ No If Yes, Give Year or Dates: Korean Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If item 27 is marked other than any Injury or other traumatic event, the IM Sales Liquor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Maisel Samuel J. Baylin 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5809 Nicholson Lane #1109, Rockville, MD Phyllis Baylin, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Judean Memorial Gardens 11-20-08 Olney, MD 4 Donation 5 Dother (Specify) 21. Signature of Filhera Service Line Torchinsky Hebrew Funeral Home 254 Carroll St., NW. Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-tran Due to (or as a consequence of): physician Physician/Medical the as aftending IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2X No 3 Probably 4 Unknown End stage renal disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 X No page 2 : certificate **2√** No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 V ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760. P.0. Division or Vital Records,

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

10

10+1

Month, Day, Year) Jeffrey A.

29b. Signature and title

29c. License number

29d. Date signed (Month, Day, Year)

30. Nar and address of verson who completed cause of death (Item 23a) (Type, Print)

Perlmutter. M.D. 6240 Montrose Road; Rockville, MD 20852

Registrar

	200		For State Registrar	State of Ma	iryiand		rtificat			i weni		jiene leg. No.	711118	331	931
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	/Medic Examin	-	4a. Facility Name (If not institution, give		<u>u</u>		4b. City,	Town, or	Location of Dea		VCIIIDC		County of Deat		
	9 . 4	Υ.	16131 Spade Road				Hag	gerst	own			İ	Washi	ngton	
- main	Funeral	1	5. Social Security Number 6. S	ex 7. Age	e (In yrs. la	ast birthday)		1 Year	If Under 24 Hi	rs. 8. D	ate of Birth	Year)	9. Birt	hplace (State o	r Foreign
	Director		220-74-3018	□M 2 <b>X</b> F	89	Yrs.				09	-03-1	919	Mar	ylánd	
	w w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside Cit	tv Limits
	f sho	or	MD Washing	ton										1 □ Yes	,
	the N	Director	10e. Street and Number	COII			10f. Zir		ISLOWII		1	0a. Citi:	zen of What Co	untry?	
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	death ms 2 r mus	Funeral	11. Marital Status	12. Was Decedent B	er in U.S	i. 13. V	Vas Dece		spanic Origin?	(Specify \	es or No-		14. Race - Ame		
0	after or ite mine		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give	lo		r res, spe 1 □ Yes			епо нісаг	, etc.)		Black, White	e, etc.	
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5	"natu	ete	15. Decedent's Ed (Specify only highest gra	lucation ide completed)		16a. Deced	lent's Usu kind of wo DO NOT u	rk done di	uring most of w	vorking		16b. Ki	nd of Business/	Industry	
7	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		none	se reureu)					nono		
7 2	filed Hygi Hygi Sther		17. Father's Name (First, Middle, Last)	1			110110		18. Mother's N	ame (Firs	t, Middle, i	Maiden	none Surname)		
0	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mentall Hygiene.  To f Health and Mentall Hygiene.  To fleet its marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be	William Hamilt	on Boyd					Marv	E		Woo	od		
2	shou and M s mar umat	-	19a. Informant's Name/Relationship (			19b. Mailin	g Address	(Street a					r Town, State, Z	Zip Code)	
2	and 2		Sarah Stallings,	cousin		P.O.	Box	135,	Friend	lship	, MD	207	58		
ט כ	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ace of Dispo- metery, cren	sition (Name	ne of other place	9)	Date		20c. Lo	cation - City or	Town, State	
	Pag ment tant: I		4 Donation 5 ☐ Other (Specif	y)	Fri	endsh				21-2			endship		
מ	permit. Pages 1 and 2 should be Department of Heath and Mental Important: If item 27 is marked ( any injury or other traumatic evoonce.		21. Signature of Funeral Service Licer	isee									1 Home,		
_	40 = 60		22a Parti Enter the disease or com	plications that sausad	the death						•		, MD 20	736 Approximate	
	4		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	e.									Interval Bet Onset and D	ween
F	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	ext	CNSIVE	2 (4	vol ic	Vascul	UVI	Dise	use		20>	<u></u>
97	Examiner			(A)	L	1 12	etav	dat	i vascul					2 (	V
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5	e exe	Ĕ	resulting in death) Last	Due to (or as a	a consequ	ence of):									
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<	certific ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	ncv							20d Date of daily		
3	eath certif attending for use as	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal	death 3□	Ectopic p					2	23d. Date of deli Month	•	Year
į	w requires that the d been signed by the should be detached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown											
٦,	s that ned b	by Pł	Part II. Other significant conditions of	ontributing to death bu	it not resul	ting in the ur	nderlying o	ause give	n in Part I.	2	3e. Did tol	bacco u	se contribute to	the cause of d	eath?
ž	equire										1 □ Y	es 2[	□No 3□Pr	obably 4 🛣	Jnknown
3	law re	plet								2	4a. Was a		24b. Were au	topsy findings a	available
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	ctor,	Be (	25. Was case referred to medical examiner?						26. Place of D	eath (Che		7	1		
	hysik this or al dire	2	1 ☐ Yes 2 ☐ ÛNo			R/Outpatien			4 LI Nursing	- 1-			6 □Other (Spec	cify)	
	Attending Physician: The lav redeath. rector: After this certificate has by the funeral director, page 2	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		28b. Time of Injury		28c. Injury Work		28d. [	Describe ho	ow injur	y occurred		
	death ctor: y the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ırv - At hor	ne. farm. stre	M eet factor		′es 2 □ No	28f L	ocation (S	treet and	d Number or Ru	ıral Route Num	her
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	or the Hospital or Attending Physician: The Attending Shury as after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	ial C	29a. Certifier 1 Certifying Ph	ysician: To the best of	of my know	ledge, death	occurred	at the tim	e, date and pla	ace, and d	ue to the c	ause(s)	and manner as	stated.	
	the Hi in 24 the Fu	edical	(Check only 2 Medical Exar	niner: On the basis of and manner sta	ted.	on and/or in				curred at	tne time, d	late and	place, and due	to the cause(s	.)
	Voit To 1	Σ	29b. Signature and title of certifier				29	c. License	_		2		e signed (Monti		
								v S	52	[5		11-	-17-2	008	
0	12		30. Name and address of person who					, im	217/0						
kı	Sta	te	Khalid Waseem, 11 31. Date filed (Month, Day, Year)	26 Upai CO 32. Registra		ure	4		Z1/4U						
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DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month John 12,2008 Busher November 1406 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3204 C Ivywood Lane Laurel Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11/24/1945 Birthplace (State or Foreign Country) Onio 7. Age (In vrs. last birthday) 274-42-0079 Months Days Hours Min. XX M 2□ F 62 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Laurel 1 ☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3204C Ivywood Lane 20724 USA 12. Was Decedent Ever in U.S. Armed Forces? 1573/es 2□No Vietnan Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1x Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☐ No White Specify. Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CPA Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Edward Busher Annie Stanielunos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia Busher Spouse 5846 Cheshire Cove Terrace Orlando, FL 32829 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 11/15/2008 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the diseased or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final card Mes disease or condition resulting in death) consequence of): Due to (or as Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 ☐ Other (specify) 9 Unknown

**Physician** /Medical Examiner

Department of Heal Important: If Item 2 any injury or other

**Physician** 

/Medical

Examiner

Director

Funeral

ð

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Midical Evander manner to notified

Il Hygiene.

Pages 1 and 2 should be filed v ment of Health and Mental Hygie int: If Item 27 is marked other?

Baltimore, Maryland 21215-0036

Examiner burial-transit and attending physician Physician/Medical the as for use the

<u>≥</u>

Completed

Be

Certification: To

Physician: The law requires that the death certificate be executed detached After this certificate has been signed funeral director, page 2 should be det. Hospital or Attending within 24 hours after deat To the Funeral Director: filled in by the

Division of Vital Records, P.O. Box 68760,

if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
IE ECMALE.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown

24a. Was an autopsy perfor 1 ☐ Yes

Chades Street, Baltimore, MD

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 □Yes 2 □No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only

25. Was case referred to medical

5 Pending investigation

Could not be determined

1 Yes 2 No

examiner'

27. Manner of Death

Natural 2 Accident

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

phycompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person

31. Date filed (Month, Day, Yeak NOV 1 8 2008

contributing to death but not resulting in the underlying cause given in Part I.

Registrar

			State of Maryland / Dep	partment of Health and Nertificate of Death		21111	38933
			Registrar  1. Decedent's Name (First, Middle, Last)	erinicale of Dealif	Re 2. Date of Death	sg. 140.	
	Physic	ian			Month	Day Year	3. Time of Death
	/Med		John Wesley Berry  4a. Facility Name (If not institution, give street and number)	45 Otto Town and a set D 11		20, 2008	11:06 p.m.
	Exami	iner		4b. City, Town, or Location of Death		4c. County of Dear	_
			St. Mary s Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Leonardtown  If Under 1 Year   If Under 24 Hrs.	9 Date of Righ	St. Ma	ry's thplace (State or Foreign
	Funera Directo		15xM 2□ F	Months Days Hours Min.	8. Date of Birth (Month, Day,		ountry)
			213-12-2720 89 IIs. Usual Residence of Decedent		Feb. 25/	/1919	Maryland
	land ow		10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Mary -f sh	호	Manual Ct Manual Lands	antan Davila			1 ∐Yes 21∑ No
	the 28a	Director	Maryland St. Mary's Lexin	ngton Park  10f. Zip Code	10	og. Citizen of What Co	untry?
	Ind 21215-0036  be filed within 72 hours after death with the Marylan ttal Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		21217 Vacancemes Diago	20653		USA	,
	ns 2:	Funeral	21217 Kearsarge Place  11. Marital Status 12. Was Decedent Ever in U.S. 13		pecify Yes or No-	14. Race - Ame	rican Indian
	fter of riter	교	Armed Forces?  1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
è	U3(	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: B1	ack
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3	y with	E O		l Servant	_   1	U.S. Gover	nment
-	othe ent,	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, M		
	'e, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Modical Examinar must be notified at	10 B	Milton Berry	Annie	Gr	ay	
	ary shou ind N		19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Rui	ral Route Number.	City or Town, State, 2	Zip Code)
	C 0	1	Julia E. Berry/Spouse 2121	7 Kearsarge Place,	Levingt	on Park N	m 20653
	<b>Ealtimore</b> , Maryland 21215-5-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or any lnjury or other traumatic event, It we Medical Exampone.		20a Method of Disposition 20h Place of Disp	nocition (Name of		Oc. Location - City or	
	no ages anto rt: If i		1 Burial 2 Cremation 3 Removal from State Immacuia	ematory or other place)		_	
3	Tip Hit I		4 Donation 5 Other (Specify) of Mary	Demetery : 11/2.	8/2008  Le	exington P	ark, MD
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			Edward N. Brinsfield, Jr. M00052 2				
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			est,	Approximate Interval Between Onset and Death
	Physician	ı	Immediate Cause (Final disease or condition resulting in death)	PROSTATE CAN	UCER		Short and Doday
- 1	/Medical Examiner		Due to (or as a consequence of):				V-101
	xamiioi	١.	Sequentially list conditions, b.				YEARS
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1	S cate	dical	d	<u> </u>			
	x c	Ĭ,	IF FEMALE:				
	<b>GOX 0</b> leath certification attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	☐ Ectopic pregnancy		23d. Date of del Month	ivery Day Year
	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		WOTHT	Day Tear
	d by	P.			Don Billion		
1 - 4	The Cords, F.O. box of The law requires that the death certifate has been signed by the attending age 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	× .
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0	as be	ble	DEMEN TIA		24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
es le	LOVISION OF VICE THE CONTROL OF A STANDARD PHYSICIEN: The law require after death.  Director: After this certificate has been sin by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Completed			perform	ed?   death?	2 No
5	OI VICAL Physician: rthis certifica	Be	25. Was case referred to medical	26. Place of Deat	h (Check only one		2 1140
7	ysic ysic lis ce direc		examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ R/Outpatie	ent 3 DOA Other: 4 Nursing Ho	me 5∏ Resider	nce 6 Other (Spec	cify)
;	ig Ph ig Ph ter th		27. Manner of Death  1 → Matural  28a. Date of Injury (Month, Day, Year) Injury Injury		28d. Describe how		,/
John	ath. Fr: Af	aţie	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
0	Afte Sir de secto	iţi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre	eet and Number or Ru	ral Route Number,
1	safte of Digital Color	ert	Formulae Building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certification: To	29a. Certifier  1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the ca	use(s) and manner as	stated.
	he Ho n 24 or Ft	edic	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occur	red at the time, da	te and place, and due	to the cause(s)
	Vithi Vomp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Monti	
			I (Aulk) ham MI)	D 40593		11/21/20	708
	7		30. Name and address of person who completed cause of death (flem 23a) (Type			1 2	
				ch Road, Hollywood	MD 206	536	
	Sta	ate	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	in itout, norry wood	200	,,,,,	
	Regist		NOV 2 6 2000 130000 150	Sparke			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2008 <u>11:</u>15A ^M Thomas Blades 24 Leonard Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ruxton Health of Denton Denton
Under 1 Year | If Under 24 Hrs. Caroline Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral ½**□M 2□F Months Days Hours Min. Director 86 221-12-9105 August 22, 1922 Delaware Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Caroline Maryland Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 10819 Greensboro Road United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1946— If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐xMarried Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1947 Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hyglen Important: If item 27 is marked other than any injury or other traumatic event, the Line Worker Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Harlon Russell Blades Lola Mae Fountain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21629 19a. Informant's Name/Relationship (Type. Print) Margaret Q. Blades Wife 10819 Greensboro Road, Denton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

⊈ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Denton Cemetery 11/28/2008 __Denton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Moore Funeral Home, P.A. Mory 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATERAL Physician KRIMARY VEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner burial-tran Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMENTIA, CHRONIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation

Box 68760. P.O. Division or Vital Records,

After this certifications funeral director, p

spital or Attendi nours after death. neral Director: A filled in by the fu within 24 hours a

To the Funeral C

completely filled

> State Registrar

Medical

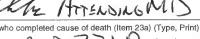
6 Could not be determined

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BLOOMINGDALEF . Registrar's Signature

DHMH 17 Rev 1/2001

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending

death,

24 hours a Hospital

within 2 To the I

completely

BAUER, RICHA Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

408

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 20, 2008 РМ November 6:45 Robert Julian Bracey 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Edenton Retirement Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Months Days Hours 1⊠KM 2□ F 95 009-26-1197 April 5, 1913 Maine Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2 TxtNo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 United States 5911 Genesis Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Baptist Ministry Clergyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Idis Clark Frank E. Bracey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8613 Burnt Hickory Cir., Frederick, MD 21704 Janice Condrey / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 KCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2008 Frederick, Maryland Resthaven Crematory 21. Signature of Fun al Service Lic Resthaven Funeral Services, Skkot Cody P.A.

**Physician** /Medical Examiner

Department of H Important: If ite any injury or ot once.

Physician

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

traumatic event, the Medical

of Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the Me

Director

Funeral

þ

Completed

Be

2

1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

3 ☐ Suicide

29a. Certifier

29b. Signature

4 Homicide

(Check only

31. Date filed (Month, Day,

6 Could not be determined

wyntensechus

NOV 2

Place of injury - At hon building, etc. (Specify)

Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

2008

physician and s the burial-tran attending p as been signed by the should be detached has e 2 , page certificate After this c funeral dire

Division or Vital Records, P.O. Box 68760,

Hospital or Attending

the

within 24 hours after death

To the Funeral Director:
completely filled in by the

		9501	Catoctin Mtn.	Hwy. Fred	erick, M	D 21701
23a. Part1. Enter the disease, or con shock, or heart failure. List or ly	nplictions that caused the death. Do not exclude a cause on each line.	ot enter the mo	de of dylng, such as cardiac	or respiratory arrest,	**	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	Pneumonia					1 week
resulting in death)	Due to (or as a consequence of	of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usaace or hour that initiated events	b. Due to (or as a consequence of	of):				
that initiated events resulting in death) Last	Due to (or as a consequence of	of):		<u>-</u>		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ⊟Ectopic p 5 ⊟ Other (s			23d. Date of de Month	livery Day Year
Part II. Other significant conditions	contributing to death but not resulting in	the underlying	cause given in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?
Congestive Heart	Failure			1 ☐ Yes	2 <b>⊠</b> No 3□P	robably 4 ∏Unknown
Hypertension				24a. Was an autopsy performed′	?   death?	utopsy findings available completion of cause of s 2  No
25. Was case referred to medical examiner?				th Check onl one		
1 ☐ Yes 2tt No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	tpatient 3 D	OA Other: 4XX Nursing H	ome 5 🗆 Residence	6 □Other (Spe	ecify)
27. Manner of Death  1   Natural  2   Accident  Accident  Accident  Accident	(Month, Day Year) Ir	ime of njury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	

Registrar

State

At home, farm, street, factory, office

🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

2050603

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Nov. 21, 2008

1475 Taney Ave. Frederick, MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 0610 AM Savannah Grace Barnes November 14, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1□ M 2□ F Director 11/12/2008 MD n/a Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Maryla thand Mental Hyglene. The mand Mental Hyglene. 77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4125 Creswell Terrace 21074 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: <u>ک</u> Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jason R. Barnes P Deanna L. (Mead) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important; If item 27 Is n any injury or other traun once. 4125 Creswell Terrace, Hampstead, Md. 21074 Jason R. Barnes, father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Carroll Cremation 11/19/2008 Hampstead, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses M00741 Eline Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hampstead, Md. 21074 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Extreme prematurity
Due to (or as a consequence of): hours disease or condition resulting in death) /Medical Examiner RESpiratory distress
Due o (or as a consequenc of): Syndrome if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transi Patent ductus Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 27. Manner of Death 1 XNatural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760. P.0. Division or Vital Records,

0

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

WIL 0

> State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melinda Elliott Sinai Hospital

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

and manner stated.

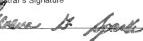
NOVEMBER 14, 2008 Baltimore, md 21215

2401 W. BEIVELETE AVE.

31. Date filed (Month, Day, Year)

29a. Certifier

32. Registrar's Signature



MJL

0

Registrar

State

Sinai Hospital

32. Registrar's Signature

30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)

Melinda Elliott

31. Date filed (Month, Day, Year)

NOVEMBER 14, 2008

2401 W. BELVELETE AVE.

Baltimore, md 21215

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month COREA NOVEMBER 22, 2008 2:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Days Hours Min Director 95 Oct. 7, 1913 286-07-6467 Ohio Usual Residence of Decedent s filed within 72 hours after death with the Maryland II Hygiene.
other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Harford 1 ☐Yes 2X No Maryland Forest Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Forest Hill Drive 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner ☐ Yes 2X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: þ If Yes, Give Year or Dates: Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Clerk Shoe Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be I Department of Health and Mental Important: If Item 27 Is marked or any Injury or other traumatic eve Umberto Salerno Rose Gorglione 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Corea/Son 917Cider Mill Lane, BelAir, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State ST. StephenCemetery11-26-08 Niles, Ohio 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Marzullo Funeral Chapel, P. A. 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) deme /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has autopsy performed? 1□ Yes 2□ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 032255 november 24, 2200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 . 32. Registrar s Signature 31. Date filed (Month, Day, Year) DEC 0 5 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008	3	3	9	4	
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		I- For State Certificate o	of Death	Reg	g. No.	
Physicia	n/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year	3. Time of Death
Medical Examin		Lucas Alexander Cedillo	FL.E	November	24, 2008	2334 hrs
		4a. Facility Name (if not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	-	(MM/DD/YYYY) 9. Bit	
Director	П	$215-83-5818$ $ _{1 \times M} _{2} =  _{F}$	Months Days Hours Min.	Oct. 2		Maryland
th the Maryland 23a or 28a-f show any notified at once.	ō	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca  Maryland Frederick Frederick  10e. Street and Number		110	g. Citizen of What Cou	10d. Inside City Limits 1 XYes 2 No
or 28	Ë	2612 Emerson Drive	21702		U.S.A.	
r death wi	by Funeral I	11. Marital Status  1 XX Never Married  2 Married  1 Yes XX No  1 Yes XX No  1 Yes XX No  1 Yes XX No  1 Yes XX No  1 Yes XX No  1 Yes XX No  1 Yes XX No  1 Yes XX No  1 X	las Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 No specify: Mex	Rican, etc.)	14. Race - Amer White, etc. Specify:	ican Indian, Black,
hours	B B	during	ent's Usual Occupation (Give kind of v most of working life. DO NOT use reti		16b. Kind of Business	Industry
36 in 72 in an "	bet	Elementary/Secondary (0-12) College (1-4 or 5+)	fant		Infant	
5-0036 led within Tygiene. other tha	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, M		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	Fredys Cedillo		ne Klein		
1D 21215 2 should be file 1 and Mental H 27 is marked o matic event, tl			ng Address (Street and Number or F			e, Zip Code)
MD id 2 sho lith and m 27 is		Fredys Cedillo, Father 2612	Emerson Drive, 1			
		20a. Method of Disposition  1XX Burial 2 Cremation 3 Removal from State crematory or c	osition (Name of cemetery, other place)	Date	20c. Location - City o	Town, State
mo Pages rent or		4 Donation 5 Other Specify:	n Mem. Gardens De	ec. 2, 2	008 Frede	rick, MD
Baltimore, permit. Pages I an Department of Hee Important: If ite	Ī	21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Keeney and Basfo	ord PA F	uneral Hom	e
	4	Richard E. Graf M00255 1 23a. Part I. Enter the disease, or complications that caused the death. Do not enter	06 East Church St	., Fred	erick, MD	21701 Approximate Interval
Physician / Medical	İ	failure. List only one cause on each line.			st, SHOCK, OF Heart	Between Onset and Death
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n of Vital Records, F dding Physician: The law requires h. After this certificate has been sign	⊢ t	27. Manner of Death 28a. Date of Injury 28b. Time of	f Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
ision Attendir r death. ector: A	틽	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No			
Division of Vital Record tal or Attending Physician: The law rec are after death.  The Director: After this certificate has bee lied in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (S or Town, St		ural Route Number, City
	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ one) 2 Medical Examiner:On the basis of examination and/or investig				
To To con	Mec	29b. Signature and title of certifier	29c. License number		29d. Date signed (Me	
		Will and	O.C.M.E.		November 25, 2	008
	-	30. Name and address of person who come eted cause of death (Item 23a)				
1			1 Penn Street, Baltimore, M	D 21201		
Sta	ite	31. Date filed (Month, Day, Year) DEC 0 5 2008	,			
Registr	ar	DEC 0 5 2008 places to produce			OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 27, 2008 **Physician** Cook 11:20 AMM Floretta /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Kline Hospice House Mt. Airy If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 6-22-1928 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F MD Yrs 80 Director 216-22-9551 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Evaniour , ust by notified at 1 ☐ Yes 2 No Director Frederick Frederick MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4016 Ballenger Creek Road 21703 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 'natural", or 1 ☐ Yes 21 No Specify. Specify: White ģ 3 X Widowed 4 □ Divorced Year or Dates Completed i Health and Mental Hygiene.
Item 27 Is marked other than "natur
other traumatic event, In Madical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Lee Johnson Grayson M. Miss ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any injury or other trai once. 1058 East Thornhill Place Frederick, MD 21703 Richard F. Cook Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crem. 12-1-2008 Smithsburg, Maryland 22. Name and Address of Facility Keeney and Basford PA Funeral Home 21. Signature of Funeral Service Lisensee M01176 21701 106 East Church St., Frederick, MD 23a. Part 1. Phier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non Alcehelre Carhysis **Physician** YMOS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Ye ar Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 Mo 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Atrice tibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Conquestive Herst Feilma 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \frac{1}{27} \) Other (Specify) Hope ( 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 046248 November 28, 2008

00 State Registrar

Baltimore, Maryland 21215-0036

Box 68760, 2

P.0.

Division of Vital Records,

31. Date filed (Month, Day, Year)

lartha

corre, MO 32. Registrar's Signature

cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

W. 9th Streat Fredombe MO

			Please	• Type or Prir State of Ma						-		_		
			1 - State Registrar			Cei	rtificat	e of l	Death		Reg. No	200	8, 38	394;
	Physici /Medic			lartha Co	urtne	y				2. Date of De Month Novembe	er la	4, 2008		P. M
	Examin	ner	4a. Facility Name (If not institution, gi Calvert County		enter		4b. City,		nce Fred		4c.	County of Dea		
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. la		If Under		If Under 24 Hrs. Hours Min.		th v. Year)	9 Bir	tholace (State	or Foreign
H	Director		Usual Residence of Decedent	1□M 2\ F		39 Yrs.		buys	Tiodis Iviiii	05/24,	191	9 Was	hingtor	
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20	in 72 hours after death with the Maryland "natural" or items 23a or 28a-f show leafical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces? 1  Yes 2  If Yes, Give X			Was Deced f Yes, spec l □Yes		ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, Whit Specify:		
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7	iled wi Hygier ther th	Co	8 17. Father's Name (First, Middle, Las	t)		Dept.	of C	orre	ctions g			Governi	nent	
yland	hould be filed within 7 1 Mental Hygiene. narked other than "r natic event, the Med	To Be	Wilson Elswor		ner				Madeli	, , ,	her	Nash		
Mary	shou and M is mar aumat	-	19a. Informant's Name/Relationship			19b. Mailin	g Address	(Street	and Number or Ru	ral Route Numb	er, City c	or Town, State,	Zip Code)	
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	permit. Pages 1 and 2 should be filed within 7 Department of Health and Metal Hygiene. Important: if fiem 27 is marked other than "7 any Injury or other traumatic event, If a Metal once.		1 Burial 2 Termation 3 4 Donation 5 Other (Special	Removal from State		ace of Dispormetery, cren			e) atory 11,			Lexandri		
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0/00	cate be physici the bu	dical		<b>d</b>										
XOO	n cerrin anding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of de	livery	
ם כ	ine dean	Physician/Medio	in the past 12 months2 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic p Other (sp		/			Month	Day	Year
CS,	To the pospular of Attending Proyscant. The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director.	þ	Part II. Other significant conditions	contributing to death bu	ut not result	ting in the ur	nderlying c	ause give	en in Part I.			ise contribute to		
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ľ	(W)		30. Name and address of person who	110,	110:	sp	Print) RO		Prince	fre	J	MD	206	3(
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 7 2008	32. Registra	ar's Signatu	parti								

08-08445 Edward August Crayle

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland's Department of Hearth and Mental Progretie

2008 38943

_		- For State Registrar	,	Certi	ficate of	Death		,	Re	g. <b>N</b> o.			
Physicia	n/	<ol> <li>Decedent's Name (First, Midd</li> </ol>	•	-			111	2	Date of Deat Month	h Day Yea	ar	3. Time of Death	
ledical Examii		Edward August				l Ol T			Month November		of Dooth	1000 1115	
f		4a. Facility Name (if not institution Route 2 and Pike Rid	-	)		b. City, Town, Edgewate		or Death		1 '			
Funeral				je (In yrs. last	t birthday)	If Under 1 Ye		r 24Hrs.	8. Date of Bir	th(MM/DD/YYYY	7) 9. Birt	hplace (State or	
Director		5. Social Security Number 219—448—4583	1X M 2 F	59	Yrs.	Months Da	ays Hours	Min.	2/12/	1949			
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Aaryland 28a-f sho 1 at once	Director	10e. Street and Number								g. Citizen of What Country?			
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r deat or it	ᆵ		1X Yes 2 ivorced If Yes, Give Year V1	etnam	1	Yes 2X	do sposific			Specifiv:	al Estate  Jory Month City of Down, State, Zip Code)  Day 733  Cation - City or Town, State  entwood, MD  al 21401  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Day Year  Date of delivery  Month Day Year  Date of delivery  Jone F. A.  Approximate Interval Between Onset and Death  Date of delivery  Jone F. A.  Approximate Interval Between Onset and Death  Date of delivery  Jone F. A.  Approximate Interval Between Onset and Death  Date of delivery  Jone F. A.  Approximate Interval Between Onset and Death  Date of delivery  Jone F. A.  Approximate Interval Between Onset and Death  Date of delivery  Jone F. A.  Approximate Interval Between Onset and Death  Date of delivery  Jone F. A.  Approximate Interval Between Onset and Death  Date of delivery  Jone F. A.  Approximate Interval Between Onset and Death  Date of delivery  Jone F. A.  Approximate Interval Between Onset and Death  Date of delivery  Jone F. A.  Approximate Interval Between Onset and Death  Date of delivery  Jone F. A.  Approximate Interval Between Onset and Death  Date of death?  Approximate Interval Between Onset and Death  Date of death?  Approximate Interval Between Onset and Death  Date of death?  Approximate Interval Between Onset and Death  Date of death?  Approximate Interval Between Onset and Death  Date of death?  Approximate Interval Between Onset and Death  Date of death?  Approximate Interval Between Onset and Death  Date of death?  Approximate Interval Between Onset and Death  Date of death?  Approximate Interval Between Onset and Death  Date of death?  Approximate Interval Between Onset and Death  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?  Date of death?		
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21215-0036 hould be filed within 77 hould be filed within 77 hold Mental Hygiene. is marked other than tire event, the Medical	m [								rginia	III- Question and the		7.0.1	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she maire event, the Medical Examiner must be notified at once	٤	19a. Informant's Name/Relation Linda Crayle	ship (Type, Print ) Spouse										
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To To Cor	Me	29b. Signature and title of certi	and manner states	d		29c. Lic	ense numbe	r		29d. Date sig	ned (Ma	onth, Day, Year)	
		Unante R	me Moull	_		0.	C.M.E.			Novembe	r 11, 2	800	
		30. Name and address of person	on who completed cause of	death (Item :									
CHIOH		Margarita Korell MD.				Penn Street	, Baltimor	e, MD 2	21201 				
	tate			rar's Signatur	k A	and .							
Regis		MONT	0 2000		ODIO								
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Division of Vita	I Records,	Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be execut	The law requires the	nat the death certificate be execut
within 24 hours after death.		
To the Consess Diseastor. After this considered the thought the offending abusining and	oto hoc boon oigno	the offerding shiping of the

			For State Registrar	State of Ma		partment of I e <i>rtificate of</i>		, ,	giene Reg. No. 200	3 3 8 9 4 4			
	Dhi.si		1. Decedent's Name (First, Middle, Last	t)				2. Date of Dea Month		3. Time of Death			
	Physici /Medic		Joseph Ernest Come	er				Novembe	er 23, 200				
	Examin	er	4a. Facility Name (If not institution, give Civista Medical (			4b. City, Town, c	r Location of Dear <b>lata</b>	th	4c. County of De				
	Funeral	7	Social Security Number     6. Se		(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. B	irthplace (State or Foreign Country)			
	Director		236-54-3293	<b>9</b> 44 2□ F	<b>71</b> Yrs.	World Suje	THOUSE IN	October 0	3,1937 We	st Virginia			
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits			
	Marylan -f show fixed at	ţ	Maryland Charle	s	Hugh	esville				1 ☐ Yes 2 XNo			
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?			
	th wit	la [	15471 Westchester	Drive		20	637		USA				
9	ours after death with the Maryla ral", or items 23a or 28a-f shov	/ Funeral	11. Marital Status 1 ☐ Never Married 2 【 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ▼N If Yes, Give	ver in U.S. 13	B. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.  Specify: White				
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination in the modified and	d by	3 Widowed 4 Divorced	Year or Dates:	10.0					1117717			
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		Be C	17. Father's Name (First, Middle, Last)	-			18. Mother's Na	me (First, Middle,	Maiden Surname)				
ylar	should by and Ments s marked umatic e	To E	Ernest Comer				Rill	a Pennin	gton				
Maryland	h and h and l ls ma		19a. Informant's Name/Relationship (7						r, City or Town, State <b>sville, M</b> I				
	s 1 and 2 of Health item 27 I		Mary Jo Comer/Wife 20a. Method of Disposition	e		position (Name of ematory or other pla			20c. Location - City				
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot		1 Durial 2 Cremation 3 ☐ 4 Donation 5 Other (Specify	)	Mt. Zior	Church C	em. 29	** 2008	Mechanicsv -Echols F.	ville, MD			
Bal	permi Depar Impor any Ir		21. Signature of Funeral Service Licens	lu De						11, MD 20622			
п			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of			nter the mode of dyi	ng, such as cardia	c or respiratory an	rest,	Approximate Interval Between Onset and Death			
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me de	/Medical Examiner		Sulting in death)  Due to (or as a consequence of):										
		e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	`									
oʻ	an an rial-tr	Еха	resulting in death) Last	Due to (or as a	consequence of):								
38760,	ficate be executed physician and s the burial-transit	dical	•	d									
4	ertifica ling pl	Med	IF FEMALE:										
Вох	leath certifi attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth : 4 ☐ Pregnant at	2 Fetal death	B Ctopic pregnan	су		23d. Date of o Month	delivery Day Year			
O.	The law requires that the death certif ate has been signed by the attending age 2 should be detached for use a	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9 ☐ Unknown	time of death ;	5 ☐ Other (specify) _							
σ,	that ned b		Part II. Other significant conditions co	ontributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?			
Records,	quires an sign uld be	ed by	Hypertensi	500				1 □ Y	es 2□No 3□	Probably 4 Unknown			
ဝ၁	e law requir has been si e 2 should l	Completed	'0					24a. Was a		autopsy findings available o completion of cause of			
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of Vital	this al di	ဥ	1 les 210-No		nt 2 ER/Outpat	elit 3200A			lence 6 Other (S	pecify)			
no	ing After une	tion	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		Wo	ryat rk? ]Yes 2∐No	28d. Describe h	ow injury occurred				
Division	Il or Attending after death. Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of inju	ry - At home, farm,			28f. Location (S	Street and Number or	Rural Route Number,			
=	i i i i i	Certification:	4 Homicide	building, etc	. (Specify)			City or Tow	n, State)				
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (	29a. Certifier Check only one)	yslcian: To the best of liner: On the basis of and manner sta	examination and/or	ath occurred at the t investigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)			
	To th withir To th comp	Me	29b. Signature and title of certifier	7		29c. Licen	se number	2	29d. Date signed (Mo	1			
	0		10	Sum	3	D6	2042		11/24	12008.			
	UB		30. Name and address of person who Karen Bauer, 28	·	, , , , , ,	e, Print)		MD 20659	)				
	Sta Registr		04 Date filed (Month Day Vent)	008 32 registra	r's Signature	hoole							
						NI HELLING							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per phys. sup. G888 2/5/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 21, 8 **Physician** 6:50PM Richard Henry Chance /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner aston Talbot Memorial HOSPITON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 🛣 M 2 🗆 F 212-34-5231 Director 71 12 1937 Maryland March Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event; the Madical Examinar must be notified at once. 1 ☐ Yes 2 X No Directo Maryland Caroline Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9755 Gannon Road 21601 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No White δ Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 1958-61 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) upholster furniture business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward George Chance Dorothy Kendall ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Ann Chance/ wife 9755 Gannon Road; Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eastern Shore Vet Cm 11/25/2008 Hurlock, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, P. PO Box 160; Greensboro, Maryland 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** dan disease or condition resulting in death) /Medical Due to (or a a consequence of in fection Examiner mary Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) A 0029818 February 4, 2009

State Registrar Danie

RICHARO

washington St. Easten, MD 21601

219

gistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abraham

4 2008

08-08913	
Victoria Clem	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certific	ate of Death	ia Meritai riyg	Reg. N	200	8 3894			
Physicia	n/	Decedent's Name (First, Middle,Last)			2.	Date of Death Month Da	у Үеаг	3. Time of Death 1555 hrs			
Medical Examin		VICTORIA ELIZ  4a. Facility Name (if not institution, give street a	ZABETH	CLEM	or Location of Death	Month Da November 27	, 2008 4c. County of Death				
		Civista Medical Center	na namber)	La Plata	or Education of Death	15	Charles	13.			
Funeral		Social Security Number     6. Sex	7. Age (In yrs. last bir				IM/DD/YYYY) 9, Bir				
Director		215-17-4663 1 M 22	Z _F 26	Yrs.   Months   Da	ys Hours Min.	FEB.10	,1982WA	SHAINGTON, D			
aux	1	10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits			
ond show	۲	MD CHARLES	WALD	OORF				1 Yes 2 X No			
Maryla Maryla dato	Director	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Cou	ntry?			
13 250 in the Maryland 23a or 28a-f sho notified at once.		4760 BRYANTOWN RO		206			U.S.A				
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	8	MICHAEL WARREN	CLEM		LINDA H	KAY THO	MAS				
ID 21 should and Mer 7 is man	은	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State									
aur aur		MICHAEL CLEM / FAT		of Disposition (Name of c			C. Location - City or				
<b>5</b>	- 1	1 X Burial 2 Cremation 3 Remo	oval from State crema	atory or other place)	DECE	EMDEK					
Baltimo permit. Page Department Important: injury or otl	ŀ	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	RESUR	22. Name and Addre				, MARYLAND			
Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep		your loster	M0064	11 5635 WA	SHINGTON	AVE.,	LA PLATA	A,MD20646			
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, k. =	Examiner	/Disease or injury that initiated C.	r as a consequence of):	<del></del>	-						
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'60, ate be ex ohysiciar	Medical		yes, outcome of pregnancy				23d. Date of deliver				
S876 rtificat ling ph	- 1	23b. Was decedent pregnant in the past 12 months?	Live birth		Ectopic pregnanc			Day Year			
Box 687: death certific	sician	1 Vos 2 No C of Hoknown	Pregnant at time of death Unknown	5 Other (Specify)							
O. Bo at the de	Phy		ting to death but not resulti	ng in the underlying cause	given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?			
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Division of Vital Records, tal or Attending Physician: The law requirers after death.  A Director: After this certificate has been side in by the funeral director, page 2 should be	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of			
Il Reccini The la	E					performe 1 <b>Y</b> Yes 2		es 2 No			
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1 of Vi	٩			Outpatient 3 DOA  Time of Injury 28c. In		Home 5 Res 8d. Describe how	sidence 6 Othe	er: 			
on of or ath.	흲	Natural 5 Pending	Date of Injury (Month, Day, Year) 28b	1		unk	. ,				
Division pital or Attencours after death teral Director: filled in by the	iiig	Z Accident	. Place of Injury - At home,		e building, etc. 2	8f. Location (Stre	et and Number of R	ural Route Number City.			
Dj Spital Pours a neral I	Certification:	4 Homicide determined (Sp	ecify) house			LaP1	ata, MD				
	Medical	29a. Certifier (Check only one) 2 Medica! Examiner: On the I									
To To com	Med		nner stated.		nse number		d. Date signed (Mo				
		Allen Brown Holl	10	0.0	C.M.E.	1	lovember 28, 2	800			
	ŀ	30. Name and address of person who complete	d cause of death (Item 23a)		-						
		- All	t Medical Examiner	111 Penn Street,	Baltimore, MD 2	1201		-			
Sta	ate	31. Date filed (Month) Day, York 2008	32. Registrar's Signature	metel							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Time of Death Month Day Year **Physician** PM 1:00 Anthony Davidson Nov 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University of 5. Social Security Number Maryland Medical Center Baltimore 8. Date of Birth (Month, Day, You Dec. 18, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Washington, D.C. 37 Months Days Hours 1 🔯 M 2 🗆 F 216-11-9907 Dec. Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. fitem 27 Is marked other than "natural", or items 23a or 28a-f show r other traumatic event, the Medical Examinant must be notified at 1 □ Yes 2 □ No Prince Georges Maryland Director Adelphi 10e. Street and Number 10134 Riggs Road 10f. Zip Code 10g, Citizen of What Country? 20783 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Specify: Afro-Am. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Business 5+ Financial Analist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John L. Davidson ഉ Marie Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie S. Davidson -Mother 10134 Riggs Road, Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important; If it any injury or o 1 → Burial 2 □ Cremation 3 □ Removal from State Nov. 21,2008 Adelphi, MD 20783 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service Inc. 7400 Georgia Ave. NW, Washington, D.C. 23a. Part 1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiraillus Pneumonia Weeks /Medical Due to (or as a consequence of): Examiner Lymphoma 2.5 years Hodakins Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a concequence of) Examir burial-trans Due to (or as a consequence of): Physician/Medical the IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a Was an autopsy 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending pl ours after death.

neral Director: After this certificate has been signed by the relation by the funeral director, page 2 should be detached. 24 hours a completely within 2 the

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number P21190

Street

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

2008

Anne E.P. 22 2 Frosch

Greene

2020 Baltimore, MD

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 1 9 2008 NOV



			101	partment of Health and Nertificate of Death	/lental		200	8 38948			
			Registrar  1. Decedent's Name (First, Middle, Last)	erincale or Dealir	2. Date o	Reg. N	No. 6 0 0	3. Time of Death			
	Physicia		Jane Alava Darby		Month Nov.		Day Ye: 2008				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death			4c. County of D				
-1			11314 Cushman Rd.	Rockville		1	Montgom	ery			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 X F	/) If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.		, Day, Yea	ar)	Birthplace (State or Foreign Country)			
	Director		Usual Residence of Decedent		Feb.	22,	1939 D	<u>elaware</u>			
	yland now		10a. State 10b. County 10c. City, Town or I	ocation				10d. Inside City Limits			
	e Mar 3a-fsl	Director	MD Montgomery Rockv	ille				1 TYYes 2 □ No			
	ith th	Dire	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?					
	eath v	Funeral	11314 Cushman Rd.	Was Dandont of Historia Origin 2 (St				ates			
	fter de	Fun	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 11. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.	) )	14. Hace · A Black, W	merican Indian, hite, etc.			
3	hours after death with the Maryland tural", or items 23a or 28a-f show at Examinar must be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🌠 No <i>Specify:</i>			Specify:	White			
215-0036	72 ho 'natur	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ina	16b.	Kind of Busine	ss/Industry			
	vithin sne. <b>than</b> "	mp	life.	DO NOT use retired) Chiatric Nurse	9		Medical				
7	be filed within 72 hours after death with the Marylan Hydjene.  It Hydjene.  It of other than "natural", or items 23a or 28a-f show event, the Awdical Exerctions in ust be notified at	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Mic						
_	ld be lental ked c	To Be	Patronio Alava	Margare			,				
Mary	2 should be filed wand Mental Hygie Is marked other traumatic event, the	-	·	ling Address (Street and Number or Rur	al Route No	ımber, City		e, Zip Code)			
e, Ge	and 2 ealth n 27 i			314 Cushman Rd. Roo	ckvil]	.e, M	D 2085	2			
ore	ges 1 If iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of ematory or other place)	Date		Location - City				
Baltimor	rtmer rtant: njury			ret Cemetery   11/21	-		shingto				
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.			22 . Name and Address of Facility $ { m Jo}$	-						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respirato	ry arrest,		Approximate Interval Between			
F	hysician		Immediate Cause (Final disease or condition Primary Lateral					Onset and Death 12 Years			
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):					12 10010			
		P.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				1				
2	d d ansit	Examiner	Cause (Disease or Injury that initiated events								
D'no/gc	physician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				_				
00/00	cate of	dical	d								
0 X	ding g		IF FEMALE: 23c. If yes, outcome of pregnancy								
XOO .	riporant. The raw requires that the beath betting this certificate has been signed by the attending trail director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of Month	delivery Day Year			
5	by the	hysi	9 ☐ Unknown								
'n	gned gned	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. C	id tobacco	o use contribute	to the cause of death?			
cords,	sen si ould b		Chronic Lymphocytic Leukemia		1	□Yes	2 X No 3 □	Probably 4 Unknown			
ט פֿ	has b	Completed			24a. V	utopsy	prior	autopsy findings available to completion of cause of			
֡֞֜֞֜֜֞֜֜֞֜֜֜֜֞֜֜֜֜֜֜֓֓֓֓֓֓֓֓֓֓֜֜֜֜֜֜֜֜֓֓֓֓֜֜֡֓֜֜֜֡֓֜֡֓	icate i, pag					erformed? s 2∭N		? es 2.⊠No			
<b>^</b>	certif	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death	,						
5	Affer this certificate has been s funeral director, page 2 should	Ë	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at			6 □Other (S jury occurred	pecify)			
	ath. r: Aff	atio	1 XNatural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No		•					
2 3	ter de Irecto	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Locatio	n (Street a	and Number or	Rural Route Number,			
ָּבְ ב	urs af										
T of	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature of the of certifier  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number									
Ę	To the	ž	29b. Signature and title of certifier	29c. License number			Date signed (Mo				
	5		1 Kolut H She m	D23556		11,	/18/200	8			
			30. Name and address of person who completed cause of death (Item 23a) (Type	· · · · · · · · · · · · · · · · · · ·		D 0:	001=				
	Stat	e	Robert H. Blee MD 5530 Wisconsin Av 31. Date filed (Month, Day, Year) Registrar's Signature		ase, M	D 20	0815				
	Registra		NOV 1 9 2008 Pregistral's Signature	WE							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Vaar PERCY LEE DYES NOV. 2008 2107 /Medical 17 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1**X** M 2□ F 218-34-9078 72 Director SEPT.20,1936 MARYLAND Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MARYLAND QUEEN ANNE'S CHURCH HILL filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 160 DIXON STABLE LANE Funeral 21623 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No If Yes, Give Year or Dates: 1954–1956 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No ģ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 **EXCAVATING CONTRACTOR** CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental ပ JOHN WILLIAM DYES JENNY WHEATLEY and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. MARIE ANNETTE DYES/WIFE 160 DIXON STABLE LANE, CHURCH HILL, MD 21623 20b. Place of Disposition (Name of CHESAPEARE) CREMATION 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 2008 CENTER STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 Kerk 9 2 23a. Part 1. Enter the disease, or commations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ial myocard disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner atheroscleroti if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 1 ☐ Yes 2 ☐ No 2 ₽No this certific al director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1⊠Yes 2∐No ٩ Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28h Time of 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending or.
s after dea.
al Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) medical manner stated. Medical 29a, Certifier completely (Check only one) the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

State Registrar

30. Name and address of person who

2 0 2008

phin

2001 Medical Park way Annapolis, mo 21401

npleter cause of death (Item 23a) (Type, Print)

32. Restrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Noah Delmas Dotson November 16, 2008 9:24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Taneytown Carroll County Country Companions If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 223-28-2130 Director 7/6/1923 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ns 23a or 28a-f sh must be notified MD Carroll Hampstead 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "And any injury or other traumation." 1725 Fairmount Road 21074 IISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1942— 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No ò Specify. Specify: white 3 Widowed 4 □ Divorced Completed 1944 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) electrician Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Dotson Gloria Campen Dotson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane M. Wardenfelt, daughter 3300 Kump Station Rd., Taneytown, Md. 21787 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State 4 Donation 5 ☐ Other (Specify) Meadowridge Memorial | 11/19/2008 | Elkridge, Md. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 934 S. Main St., Hampstead, Md. 21074 Lemmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No cate ha 1□ Yes a No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2

State Registrar 30. Name and address of person who com

NOV

Year,

8

31. Date filed (Month, Day,

WJLVA

DHMH 17 Rev 1/2001

Certificate of Death

Reg. No.

1916

4c. County of Death

Montgomery

2:38 a M

Birthplace (State or Foreign Country)

North Dakota

November 17, 2008

2. Date of Death Month

Jocelyne

19 2008

31. Date filed (Month, Day, Year)

For State Registral

**Physician** 

1. Decedent's Name (First, Middle, Last)

Syvia K. Epstein

10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country? U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 ☐Yes 2 🛣No Specify: White Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home 18. Mother's Name (First, Middle, Maiden Surname) Frances Badesch daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9913 Juniper Hill Road, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Mt. Lebanon Cemetery 11/19/2008 Adelphi, Maryland 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 No 2 No 1 □Yes 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Home 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License nymber 200 6374 8 29d. Date signed (Month, Day, Year) Kouatchou, mi November 18, 2008 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Jocelyn Toukep KouatchouMD 1355 Piccard Drive, Rockville, Maryland Registrar's Signature **ORIGINAL** 

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar AMEND#290 per MD11/20/08, EMW, MoCo Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Elaine FINKEL 2008 7:20 A M 15. November /Medical 4b. City, Town, or Location of Death Bethesda 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year **Funeral** Days Min. Months Hours 1 □ M 2 👿 F Pennsylvania 83 4, 197-16-7091 1925 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State must be notified at N. Bethesda 1 ☐ Yes 2 ☐ No Montgomery Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examinar must be an once. 20852 United States 10301 Grosvenor Place #2103 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Celia Kruger Harry Herskowitz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10301 Grosvenor Pl., #2103, N. Bethesda, MD 20852 Mitchell Finkel, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 11/17/08 Olney, MD 21. Signature of Foneral pervice Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMOWMY CMOID MABT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DISSOCIANG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ATITUDSCLONOSIS burial-tra Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 □Yes 2 🛂 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Nonknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

attending physician for use as the buria After this after death To the Hospital c within 24 hours at To the Funeral C completely filled

the Maryland

Baltimore, Maryland 21215-0036

28a-f show

been signed by the should be detached filled in by the funeral

State Registrar

29c. License number

29b. Signature and title of certifier W

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROTET

20814 Bethesda, MD

8600 OLD COUNTO TUNN

31. Date filed (Month, Day, Year)
NOV 1 9 2008

amend #23a&e Per PHY 9886 12/19/08 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8:50 a M David Sidney Feldmann November 15, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 12433 Triple Crown Road Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 2 M 2 □ F Months Days Hours Min. Director 214-28-4196 77 07/14/1931 Washington, D.C Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 √ Yes 2 No Director MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with toent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23a or: 12433 Triple Crown Road 20878 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 □ Never Married 2 N Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isadore Feldmann Pauline Levy ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 19a. Informant's Name/Relationship (Type. Print) J.K. Feldmann, wife 12433 Triple Crown Road, Gaithersburg, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of I Important: If its any injury or o oonce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdns 11/18/2008 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, Mary land 20852 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sarcoma Rhabdomyosarcoma **Physician** disease or condition resulting in death) 10 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events Due to (or as a consequence of): Examine burial-transi and resulting in death) Last Due to (or as a consequence of) physician at the burial Physician/Medical a puibo use as IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death atter for u 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a detached ☐Yes 2☐No 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes XXNo Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 □Yes 2K No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ nours after death.

neral Director: After this
filled in by the funeral di this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 TYes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a, Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D45880 November 17, 2008

State Registrar 31. Date filed (Month, Day, Year) 19 Registrar's Signature

Leon C. Hwang, MD, 1396 Piccard Drive, Rockville, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

20850

the Maryland

Baltimore, Maryland 21215-0036

certificate be executed

The law requires that the death

Physician:

the

P.O.

of Vital Records,

Division Hospital or Attending

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** RuthGFrazier 2:17PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Tourey to uun Taneytown orien If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 214-36-9406 Director WVUsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No **Funeral Director** MD Carroll Taneytown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? filed within 72 hours after death with 21787 4819 Feeser Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Completed by Specify. Specify: white 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene.
7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William M. Keene Louisa Luster 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is many injury or other once. 4819 Feeser Rd. Taneytown, MD 21787 Louise Arvin / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 X Removal from State Mount Carmel Cemetery 11/20/08 Littlestown, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 17340 PALittle's F.H. 34 Maple Ave. Littlestown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, ne. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To ours after death.

Ieral Director: After this (filled in by the funeral dir 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 9 To the Hospital c within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) WJL person who completed cause of death (Item 23a) (Type, Print) Sheet . Date filed (Month, Day, 32. Registrar's Signature Year. State Registrar NOV DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

08-08906 Jay A. Craig Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Examine	r	JAY	ALLEN		IG J	₹.		al anation of		November 2	7, 2008 4c. County 0	of Death	10.
	4a		if not institution, give	street and number)		4	b. City, Town, La Plata	or Location o	Death .	*	Charles	- 1	- 3
			dical Center	17 Age	e (In yrs. last	hirthday)	If Under 1 Y	ear If Under	24Hrs. 8	3. Date of Birth(	MM/DD/YYYY	g. Birth	place (State or
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hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	- 1	1. Marital Status		12. Was Decedent	Ever in U.S.	13. Wa	s Decedent of es, specify Cu	Hispanic Orig	jin? ( Spec , Puerto Ri	cify Yes or No- can, etc.)		e - Americ te, etc.	an Indian, Black,
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To the within To the comple	Medical		and title of certifier	and manner sta	ted.	,		License num			29d. Date	signed (f	Month, Day, Year)
<b>4</b>	-	255. Oigilature		20/	11			O.C.M.E.			Novem	ber 28,	2008
		20 Name and	address of person v	no completed cause	of death (Ite	m 23a)							
		Jack Tit		ity Chief Medica	al Examine	er 111 F	Penn Stree	t, Baltimor	e, MD 2	1201			
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2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 29e. Location (Street and Number or Rural Route Number, building, etc. (Specify) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 1 2008 32. Refistrar's Signature 33. Date filed (Month, Day, Year) 1 2008 34. Date filed (Month, Day, Year) 1 2008 35. Refistrar's Signature 35. Refistrar's Signature 36. Refistrar's Signature 36. Refistrar's Signature 37. Date filed (Month, Day, Year) 1 2008 36. Refistrar's Signature 37. Date filed (Month, Day, Year) 1 2008 36. Refistrar's Signature 37. Date filed (Month, Day, Year) 1 2008 36. Refistrar's Signature 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Year) 1 2008 37. Date filed (Month, Day, Y	Ing P		1 Natural 5 □ Pending (Month, Day Yea				28d. Describe h	now injury occ	curred		
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ynthia Anne Fr		1- For State A	Statemend It	te of Maryland cem 21 per	Depart	ment of L	ealth and Mer	ntal Hygiene	20	08 38957
Physicia Medical Exami	n/	1. Decedent's Name Cynthia	(First, Middle,I	Fritz			<u> </u>	2. Date of		3 Time of Death 1745 hrs
Funeral		4a. Facility Name (if 133 Summit 5. Social Security Nu	Avenue Ap		- A I	F	City, Town, or Location		4c County Washin	gton
Director		187–50–02 Usual Residence of	27		6 (In yrs. last		f Under 1 Year I If Und Months Days Hour	. 1.0-	of Birth (MM/DD/YYY) y 27,1958	Y) 9. Birthplace (State or Foreign Country <b>Virginia</b>
Maryland 28a-f show any 1.at once,	Director		Ob. County Washin	igton		gerstow	<b>1</b> Of Zip Code		10g Citizen of W	10d Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f sho	- 1	1022 Brin	ker Dri	ve Apt. 101	771	701	21740		USA	
72 hours after death with the Maryland n"natural", or items 23a or 28a-f she al Examiner must be notified at once	by Funeral	Never Married  Widowed	4 Divord	1 Yes 2  If Yes, Give Year or Dates:	X No	If Yes,	ecedent of Hispanic Ori specify Cuban, Mexicar s 2 X No specify	n, Puerto Rican, etc	) Whit	e, etc.  White
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours a ment of Health and Mental Hygiene rant: If item 27 is marked other than "natural or other tranmatic event, the Medical Examin	Completed	Elementary/Secon	ndary (0-12)	conly highest grade comes College (1-4 or 9	5+)	during most	Jsual Occupation (Give of working life DO NOT red Nurse	use retired)	Priv	ate Care
21215-0036 Juld be filed within 7 Mental Hygiene marked other than ic event, the Medica	8		erman B	arnhart Jr.			Mati	1da Anne		,
ore, MD 2 es land 2 shoul of Health and IV If item 27 is m	۵		Shatzer	(Type, Print)  - brother		3905 Bi	dress (Street and Nur 111frog Roa	d, Taneyt	own,MD 21	787
Baltimore, permit Pages I an Department of He Important: If ite		20a Method of Dispo 1 Burial 2 3 4 Donation 5	<b>X</b> Cremation	3 Removal from Sta	ite crer	matory or other	(Name of cemetery, place)  Crematory	Date 11/08/08		City or Town, State
Balti permit Departr Import injury		21. Signature of Fund James Sp:		per dvr		22. Name	e and Address of Facility  E. Wilson	LITHITCI	Funeral lagerstown	Home , MD 21740
Physician /Medical Examiner		23a. Part I. Enter the failure. List only Immediate Cause (Fi or condition resulting	one cause on inal disease	mplications that caused each line. a. Contact Shotgui	n Wound t		ode of dying, such as c	cardiac or respirator	y arrest, shock, or he	Approximate Interval Between Onset and Death
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate  Course Enter Underlying Cauce (Disease or injury that initiated events resulting in death) Last  b								
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ls, P.O. I	출	Part II. Other signific	cant condition	s contributing to death	but not resul	Iting in the unde	rlying cause given in Pa	1	Yes 2 ✓ No 3	
Division of Vital Records, ral or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed	25 Mas 2022 referen	44					1 <b>V</b> Y	utopsy performed? c	Were autopsy findings available prior to completion of cause of leath?  Yes 2 No
Vital Tysician This cert	삙	25. Was case referre examiner? 1 ✓ Yes 2	No No	Hospital: 1 Inpatier	nt 2 ER	t/Outpatient 3	26.Place of Death DOA Other	(Check only one) Nursing Home 5	Residence 6	Other Scene
Sion of Attending Ph death. ctor: After ty the funeral	ation	27. Manner of Death  1 Natural  2 Accident	5 Pending	ation Nov 4, 2008	F( 17	b. Time of Injury OUND: 743 hrs	1 Yes 2 🗸	No Shot self		
Divis Hospital or A 24 hours after Funeral Dire	Sertif	3 Suicide 4 Homicide	6 Could no determin	ot be			ctory, office building, et	or Tov	on (Street and Numbern, State) nit Ave. Apt.#6, Ha	er or Rural Route Number, City gerstown, MD
Di To the Hospital within 24 hours a Within 24 hours a To the Funeral I	edical	one) 2 🗸 M	ledical Examir	ician: To the best of my ner:On the basis of exam and manner stated.						
	Ž	29b. Signature and tit	tle of certifier	M. C			O.C.M.E.		29d Date signe November	ed (Month, Day, Year) 5, 2008
	ſ	30 Name and addres		o completed cause of dev V Chief Medical Ex		•	treet Baltimore I	MD 21201		

State

31. Date filed (Month, Day Year) DEC 0 5 2008

Goards.

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2000 Thressiamma George Novemb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6206 Cody Court Beltsville Prince George's Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 □ M 2 🖾 F Months Hours 219-69-1584 May 28, 1941 India Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🖾 No Director Maryland Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a 6206 Cody Court 20705 Funeral India 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Completed by Specify 3 ☐ Widowed 4 ☐ Divorced "natural" Asian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F Ouseph George Maria Mary 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trat once. Salvi Puthussery - Son 6206 Cody Court, Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 11/22/2008 4 ☐ Donation 5 ☐ Other (Specify) Christ the King Cemetery Trichur, India Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** Theroscherotic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Box 68760, 65 Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy cate has been signed by the atter page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 res 2 No 1 Inpatient Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: A
d in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 31. Date filed (Month, Day, Year) egistrar's Signature State 19 2008 Registrar

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100			2825 Lookout Trail	Huntingtown			Calv	ort	
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10.0	11.1		30. Name and address of person who completed cause of death (Item 23a) (Type		1	MD 222	7.0		
XKV	UTI		J. Fears, M.D., 110 Hospital Rd., St 31. Date filed (Month, Day, Year) 32. Registrates Signature	ce. 310, Prince Fre	ederick,	MD 206	/8		
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			For State Registrar	State of M	aryland /	Depa <i>Cei</i>	artment <i>rtificate</i>	of He	ealth a Death	ınd M		giene U	18	38950
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	/Medic Examin		4a. Facility Name (If not institution,  Anne Arundel Me			4b. City, Town, or Location of Death Annapolis					4c. County of D Anne Ar			
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	aryland show	_	Usual Residence of Decedent  10a. State 10b. County  MD Anne A	rundel	10c. City, Tox		cation OWNSVi	116						10d. Inside City Limits 1 ☐ Yes 2001No
	ith the Marylan or 28a-f show	irecto	10e. Street and Number	- under			10f. Zip C					10g. Citizen of V	/hat Cou	
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9200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat natural be notified at once.	d by Funeral Director	11. Marital Status  1 Never Married XX Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces  MXYes 2 If Yes, Give Year or Dates:	?		Was Decede f Yes, specif 1 ☐ Yes 21		panic Oric , Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. Race Blac Specify	k, White	ican Indian, , etc. White
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Baltimore,	Pages 1 annent of Heannert if item		20a. Method of Disposition 1			ery, cren idy (	natory or oth of the	er place Fie	elds	11/1	8/2008	20c. Location - Millers	vill	e, MD
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O. Box	that the death certific ed by the attending p detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deat		Ectopic pred Other (spec					23d. Dat Mor		rery Day Year
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1	otiCH		30. Name and address of person v	AAM	C 300	210	Print)	9) -	Rack	rest	Ana.	2015	Med	21401
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 3:58 PM Margaret Ann Giddings November 21, 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Taylor Farms Assisted Living Avenue If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 👿 F 577-50-8558 May 15, 1932 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 26006 Dallas Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Dunham Smith Martha Ann Potter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karin Weining / Daughter 9 Polaris Street Newark, DE 19711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 23. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset ang/Death Immediate Cause (Final mena disease or condition resulting in death) Due to for as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 2 2 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 ☐ Yes 2 🖪 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Box 68760, P.O. Records, of Vital Division **Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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**Funeral** 

Director

show

item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ire Madical Examinant must be redified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event

**Physician** 

/Medical

Examiner

attending physician and for use as the burial-trar

72 hours after

Maryland 21215-0036

Baltimore,

law requires that the death certificate be executed signed by the a Completed has page 2 Physician: The certificate funeral director Be Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After or Attending 5 ☐ Pending investigation 1 Matural 24 hours after death. Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the within 2 To the F 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) 24035 Three Hollywood, MD 20636 otch Road

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Maryland / Dept	rtificate of Death		. No.	
	Physicia		1. Decedent's Name (First, Middle, Last) Martha E. Grif:	fith		2. Date of Death Month NOV. 2	Day Year	3. Time of Death 10:44 AM
	/Medic	al -	4a. Facility Name (If not institution, give str		4b. City, Town, or Location of Death		4, 2008 4c. County of Deeth	
	LAGIIIII		Caroline Nursi		Denton  If Under 1 Year   If Under 24 Hrs.	O Date of Birth	Caroli	_
ı	Funeral Director		214 30 7044	7. Age (In yrs. last birthday) 7. 7. 7. 7. 7. 7. 7. 7. Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	Sept. 2	(ear) 1933 Mar	place (State or Foreign ntry) y Land
	Maryland -f show		Usual Residence of Decedent  10a. State 10b. County  MD Carolin	10c. City, Town or Li	Federalsburg	3		10d. Inside City Limits 1 ☐ Yes 2,☐,No
	with the 3a or 28s	il Director	10e. Street and Number 26759 Idlewild	Road	10f. Zip Code 21632		p. Citizen of What Cou United St	•
0000	be filed within 72 hours after death with the Maryland Hydione.  do ther than "netural", or items 23a or 28a-f show do ther than "netural", or items 23a or 28a-f show event, the Medical Exactifier regal be netified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 _Yes 2 _XNo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White Specify:	
M-6121	vithin 72 hou ne. han *netura e Medical E	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	completed) (Give	edent's Usual Occupation a kind of work done during most of wor DO NOT use retired) shier	king	Bells Cu	
7	e filed within al Hygiene. I other than vent, the Me	Be Co	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma		
Jana		To B	Milton Gray Tow			Whitby		
Mar	s 1 and 2 should Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ Arnold Griffith		ing Address (Street and Number or Ru 59 Idlewild Road,			
more,	Pages 1 ar		20a. Method of Disposition 1 △Surial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)		osition (Name of smallory or other place) st Cemetery Nov.		oc. Location - City or T Federalsbu:	own, Stete rg, Maryland
ранитог	permit. Pages Department of h Important: If ite any injury or of		21. Signature of Funeral Service Licenses	n. Coule	22. Name and Address of Facility F. 216 N. Main St.,	ramptom Fu Federals	uneral Homo ourg, MD 2	e, P.A. 1632
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, 20,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to init collate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
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O. Box	he death certi the attending shed for use a	Physician/M	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
7	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions conf	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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Vita	ician: certific rector,	Be	25. Was case referred to medical examiner?	ospital:	Other:	ath (Check only one	) nce 6 ⊡Other (Spec	ii6.)
Division of	Attending Physician: or death. ector: After this certific by the funeral director,	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ ER/Outpatient of 28c. Injury at	28d. Describe how		ury)	
DIVISI	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical	29a. Certifier Certifying Phys	ician: To the best of my knowledge, dea er: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	10	29c. License number	29	d. Date signed (Month	n, Day, Year)
			Janes	Jelon M	D D 3137	6 1	1-25 2	0
			30. Name and dddress of person who co	mpleted cause of death (Item 23a) (Type	> 920 Marl	TET S	Dort	ON 42
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature				

			For State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of St	artment of Health and N rtificate of Death	-	eg. No 2 0 0 8	38963
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ic .	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
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	and w	ł	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
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	the N	Director	MD. Carroll Hampst  10e. Street and Number	10f. Zip Code	1	0g. Citizen of What C	ountry?
	3a or		18411 Gunpowder Rd.	21074		USA	
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	To th Vithir To th COMP	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	nth, Day, Year)
	JEW		I hom W modellom MD	D25443	<b>&gt;</b>	4/14/2	2008
	2		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	·	/	
		17	John W. Middleton M.D. 3337 Victor	y Street, 7	nonche	ester, A	1P21102
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature	A. W.			

DHMH 17 Rev 1/2001

ORIGINAL

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2008 38964 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Angel Boanerge Zunun-Gomez 1- For State

<u> </u>		Registrar	lo Loot			tinouto o.				2. Date of Dea	eg. No.	3. Time of Death
Physicia edical Examin	er	1. Decedent's Name (First, Middl Angel Boaners	ge Zui	nun Gom	ez	·		, ort !!		Month	Day Year r 20, 2008	0715 hrs
		4a. Facility Name (if not institution 404 Thawley Road	n, give stre	eet and number	)	4	b. City, Town Denton	, or Location	n of Death		Caroline	
Funeral Director		5. Social Security Number N/A	6. Sex	ì	ge (In yrs. Ia	ast birthday) Yrs		Year If Un Days Hou	der 24Hrs. Irs Min.		rth(MM/DD/YYYY) 9. For 4 1978	Birthplace (State or eign ^{Country)} Mexico
·		Usual Residence of Decedent  10a. State 10b. County			Inc. City	Town or Locati	on					10d. Inside City Limits
d how any e.	Ι,	Maryland Carol	ine			arydel	011					1 Yes 2 X No
larylan 28a-f sl	- L	10e. Street and Number	Line			ar jaor	10f. Zip Coo	le			10g. Citizen of What C	ountry?
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y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X M	larried 1			If Y	es, specify Cu	ıban, Mexic	an, Puerto		White, etc	
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"hours		15. Decedent's Education (Spe Elementary/Secondary (0-12)		College (1-4 or			ost of working				Tob. Tind of Edonie	
0036 within 72 jene. ner than	Completed	12	L L	03	,	lab	orer				golf cou	rse
21215-0036 Muld be filed within 7 Mental Hygiene marked other than event, the Medica		17. Father's Name (First, Middle	, Last)					18.Moth	ner's Name	(First, Middle	Maiden Surname)	
121 libe fill ental li arked	Be	Angel Zunun I				405 Mailin	a Address (S	Ang	elina	Gomez	Perez umber, City or Town, St	tate Zin Code)
D 2 should and M 7 is ma	٩	19a. Informant's Name/Relations Daniel Zunun			her	200					, Maryland	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		1 X Burial 2 Crematio		Removal from S		crematory or ot nto Don		em	N/A		Mexico	
altin mit. P partme portar ury or		4 Donation 5 Other S 21. Signature of Funeral Service				Tool	Jamo and Ado	troce of Eac	ility	hada E	umanal IIam	o DA
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O, be ex	edic	UNPENDED		MENDED							23d. Date of del	ivery
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P.O. Box 6: s that the death cert gned by the attendii	sicia	past 12 months?  1 Yes 2 No 9 Ui			at time of d	o o th	ther (Specify)				1	
Box the death of y the atten shed for us	Physici	Part II. Other significant cond		Unknown	ath but not	resulting in the	underlying ca	use given ir	Part I.	23e. Did	tobacco use contribut	e to the cause of death?
, P.O ires that to signed by I be detact		Tarti. Other signmount conc		Thirty dailing to do				3		1 🔲 ነ	'es 2 ✔ No 3	Probably 4 Unknown
ords, F v requires s been sign should be	Completed by									24a. Wa		e autopsy findings available to completion of cause of
e law reque has been ge 2 should	mpl										formed? deat	
tal Rec		25. Was case referred to medic	al			<u> </u>	26.1	Place of De	ath (Check	1,500		
Vital I ysician: this certifi director,	o Be	examiner? 1 ✓ Yes 2 No	Hos	pital: 1 Inpa	itient 2	ER/Outpatier	it 3 DOA	Other	Nursi	ng Home 5	Residence 6	Other: Scene
on of Vil ending Physicath. et: After this	tion: T		nding	28a. Date of In (Month, Da Nov 20, 20	njury v.Year) 08	28b. Time of 0655 hrs	· · ·	. Injury at W			e how injury occurred er auto auto collisi	ion
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi	Certification	3 Suicide 6 Co	estigation uld not be termined			home, farm, str		fice building	g, etc.	or Town		or Rural Route Number, City d.
Di To the Hospital within 24 hours a To the Funeral I	Medical C	29a. Certifier Certifying	aminer: O	n the basis of e	xamination	dge, death occi and/or investig	urred at the tir ation, in my op	ne, date and pinion, death	d place, and n occurred	d due to the ca at the time, da	ause(s) and manner as te and place, and due	stated. to the cause(s)
To with	Med	29b. Signature and title of certi		nd manner state	su.		29c. L	icense num	ber			(Month, Day, Year)
		Calisa	11	1	1	1		D.C.M.E.			November 21	, 2008
_		30. Name and address of person					C4	Doltin	- MD 04	1201		
		Zabiullah Ali, M.D.		ant Medical			nn Street,	Baitimor	e, MD 2	1201		
St	tate	31. Date filed (Month Par Yea	4 20	በጸ ^{32.} የ	trar's Signa	iture	Section 5					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:05P Donnie Holmes 15,2008 November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3060 Eutaw Forest Drive Waldorf Charles Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Sex 14☐ M 2☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min Yrs 524-44-7906 Director 66 March 15, 1942 OR Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner well be notified at 1 ☐ Yes 2√ No Director MD Charles Waldorf 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3060 Eutaw Forest Drive 20603 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☐ No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Assembly of God 4 Minister 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Marshall Holmes Ruby Copeland ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3060 Eutaw Forest Dr. Waldorf, MD 20603 Carolyn Holmes/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State County Line Cemetery | 11/20/2008 Pickens , OK 4 ☐ Donation 5 ☐ Other (Specify) Signature of Jungal Service M01458 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. once 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 80 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably ≒ Unknown cate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2170 Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \sum \) Nursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manoer of Death Injury 1-Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital or 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, 29b. Signature and title of certifier 29c. License number 0 Krishan, Mathur, M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 9 the start Registrar

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I <i>rtificate of</i>		lental Hy		2008	38960		
ı	Physici	an	1. Decedent's Name (First, Middle, La JOHN LEWIS	,				2. Date of De	eath Day	v Year	3. Time of Death		
~.	/Medic		4a. Facility Name (If not institution, gi			4b. City, Town, o	r Location of Death	NOV.	12,	2008 County of Deat	10:44A ^M		
			Holy Cross H	ospital			r Sprin		M	ONTGOM			
	Funeral Director		256-88-3518	Sex 7. Ag	e (In yrs. last birthday, 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Nov.]	rth <i>ay, Year)</i> L <b>,1</b> 9.	51 Geo	hplace (State or Foreigr untry) Orgia		
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits		
	a-f sh	ctor	MD Montg	omery	Gai	thersbu	ırq				1 ☐ Yes 2 🔣 No		
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Cou	untry?		
	s 23a		18338 Honeylo			2087				U.S.A.			
036	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Evanthar must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married ※ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 113.	Was Decedent of F If Yes, specify Cuba 1 □Yes 2X No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	0-	14. Race - Amer Black, White Specify: Bla	, etc.		
2-0	72 hor	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	i (Give	dent's Usual Occup	durina most of worki	'ng	16b. Ki	ind of Business/I	ndustry		
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מ מ	other	Be C	17. Father's Name (First, Middle, Last	)	11.3		18. Mother's Name	e (First, Middle					
<u>Xa</u>		To E	Harvey Harri	S				red Jo					
, Maryland 21215-0036	ss 1 and 2 should of Health and Mer item 27 is marke r other traumatic	1.1	19a. Informant's Name/Relationship Mary Kackley-		Wife) 183	338 Hone	ylocust	Route Numb	er, City o	aithers	sburg,MD		
saltimore,	E = 6		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Dispo cemetery, crei			Date		ocation - City or T	· —		
	permit. Pag Departmen Important: any injury once.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice			Cremato		20/08   DWDEN		nover,	MD OME, P.A.		
ä	Dep any		Deseas	A A							MD 20850		
1	Physician		23a. Part 1. Enter the disease, ir comshock, or heart failure. Ist only Immediate Cause (Final disease or condition	one cause on each lir	ne.	5.50		or respiratory a	arrest,		Approximate Interval Between Onset and Death		
· ;	/Medical Examiner		resulting in death)	Due to (or as	spiratory a consequence of):	rattur	Е						
		e	Sequentially list conditions,	b. Mer	tastatic	Lung Ca	ncer			7.4			
	cuted nd ransit	Examiner	Sequentially list conditions, it as years to instruct a cause. Enter Underlying Cause (Disease or injury that initiated events	C									
Š,	tificate be executed g physician and as the burial-transit	Ex	resulting in death) Last	Due to (or as	a consequence of):								
09/90	icate I physic the b	edical		d									
.O. Box	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	у		2	23d. Date of deliv	very Day Year		
ν.) -	ss that gned I	by P	Part II. Other significant conditions			nderlying cause give	en in Part I.	23e. Did t	tobacco us	se contribute to	the cause of death?		
25	requir een si nould l		S/P Pericar		dow			1 🗆 '	Yes 2	□No 3□ Pro	bably 4½ Unknown		
ORANDO ORANDO	The law acate has b	Completed	Leukocytosi	S				24a. Was auto perfo 1 🗆 Yes	psy ormed?	24b. Were autoprior to codeath? 1 ☐ Yes	opsy findings available ompletion of cause of		
- Z	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death	(Check only o	one)				
5 ξ	Phys er this eral dii	5	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Inju	ent 2 ER/Outpatier		4 LI Nursing Hor	ne 5 Resi			ify)		
2 Å	arth. rr: Afte	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	v, Year) Injury	28c. Injury Work	Yes 2 □ No	od. Besonibe	now inguity	Codified			
2/4 50	tāl or Atters after des al Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At home, farm, street. (Specify)	eet, factory, office	2	28f. Location (: City or To	Street and wn, State)	d Number or Run	al Route Number,		
50x 23	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  1 ★ Certifying Ph 2 ★ Medical Example 1	ysician: To the best on iner: On the basis of and manner sta	of my knowledge, death f examination and/or in ited.	n occurred at the tir vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due t	stated. to the cause(s)		
	with Con London	Σ	29b. Signature and title of certifier			29c. License				e signed (Month,			
	f	-	Hotels	m.D.			68096		13	1/12/08	}		
			30. Name and address of person who Satyam Shad,	M.D. 150	00 Forest		d, Silve	er Spr	ing	, MD 20	)910		
	Stat Registra		31. Date filed (Month, Day, Year)  NOV 1 9 200	8 Registra	ar's Signature	E)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Eric Monroe Jackson 28, 2008 19:24 /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 525 Ferdinand Drive Harford Havre de Grace If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** 9/23/1940 Days Hours 10 M 2□ F 219-36-0537 68 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumails event, the Medical Examiner must be notified at Harford Havre de Grace MD 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 525 Ferdinand Drive 21078 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1.⊟Yes 2 No If Yes, Give Year or Dates: 1960–1966 and 2 shor Id be filed within 72 hours after ealth and Mental Hygiene. 1 ☐ Never Married 2 ★ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mail carrier Postal 12 h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Leroy Jackson Dorothy McIntosh 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Judith Ann Jackson (Spouse) 525 Ferdinand Dr. Havre de Grace, MD 21078 Baltimore, permit. Pages 1 a Department of Hea 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 3 Removal from State 1 ☐ Burial 2 ☐ Cremation 4 □ Donation 5 ☑ Other (Specify) Mausoleum injury Harford Mem. Mem. Gdns.

22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.

Marvland 21001-3399 12/6/08 Aberdeen, Maryland 21. Signature of functal S ans 23a. Part1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 🔲 inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 36. Name and address of person who completed cause of death (Item 23a) (Type, Print) a 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Iva Lee Johnson November 2008 10:28 AMM /Medical 4a. Facility Name (If not Institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 20100 Rohrersville School Road Rohrersville Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1924 West Virginia 1 □ M 3/3/F Months 212-38-9746 83 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural" or items 23a or 28a-f show any Injury or other traumatic event, it is Nexical Emminer must be notified an any Injury or other traumatic event, it is Nexical Emminer must be notified an approxe. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland | Director Frederick 1 ☐ Yes 2√No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6200 Fairfax Court 21704 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. <u>م</u> Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Hesbia Foster Beatrice Martha Snapp ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21779 Mrs. Phyllis Lee Baker, daughter 20100 Rohrersville School Rd., Rohrersville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) .20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery Dec. 3, 2008 Frederick, MD 21. Signature of Euneral Service License Name and Address of Facility Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 100 disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of) Physician/Medical IF FEMALE 23d Date of delivery

Month

29d. Date signed (Month, Day, Year)

December 1, 2008

Day

3 ☐ Probably ► Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760, න physician s the burial attending pl pe 2 should page certificate Hospital or Attending Physician:

funeral director, After this 24 hours after deat

þ

Be Completed

Certification: To

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24a. Was an autopsy 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital. Other: 4 \sum Nursing Home 5 Residence 6X Other Specific 15 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Mapner of Death 28b. Time of 28d. Describe how injury occurred atural 5 Pending 2 Accident investigation 1 Tyes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie

Registrar

completely

To the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Casper E. Cline, III, M.D., 300 West Ninth Street, Frederick, Maryland 21701

31. Date filed (Month, Day, Year) DEC 0 5 2008

29b. Signature and title of certifier

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D16428

	4	For State		State of IVI	aryiano		artment of		nd Me	ntai Hy	giene		
	•	Registrar				Cer	rtificate of	Death			Reg. No.	008	3896
Physician /Medical	1		ne (First, Middle, Last JANE JONES	•					1.	Date of De Month	Day	Year 2008	3. Time of Death 2242
Examiner		1a. Facility Name (	If not institution, give	street and number)			4b. City, Town,	or Location of	Death		4c. Coun	nty of Death	n
	ı	Mem	orial H	bospital	•		E	ASTOI	S		TF	4160	T
uneral	5	5. Social Security N			ge (In yrs. la		If Under 1 Year Months Days		Hrs. 8	. Date of Bir (Month, Da	th av Year)	9. Birth	hplace (State or Forei
rector		219-36-6	0/6/	□ M 2 <b>X</b> F	68	Yrs.	World Day	110013		UNE 26			YLAND
>	$\vdash$	Usual Residence of	f Decedent 10b. County		100 City	Town or Loc	notion						dod Inside City Lines
or 28a-f show					,								10d. Inside City Limit
or 28a-f st	3	MD	CAROLII	NE	GRI	EENSBO					4	(111)	
Di	,	10e. Street and Nu		T.			10f. Zip Code				10g. Citizen o	of What Col	untry?
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Expeditude 1 once.  To Be Completed by Funeral Director	3		RCH STREE		Fire-in II C	40.4		1639	0.40	f N	USA		
E E	1	11. Marital Status	ried 2 Married	12. Was Decedent Armed Forces?		. 13. V	Was Decedent of f Yes, specify Cu	ban, Mexican, F	n? (Speci Puerto Ric	ty yes or No can, etc.)	)-   14. H	ace - Amer lack, Whit <i>e</i>	rican Indian, , etc.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** George A. Kupets, Sr. 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedale
If Under 1 Year | If Under 24 Hrs. | Hours | Min. Square Baltimore tranklin Hospital Center 6. Sex 1 2 M 2 □ F Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months 71 Director 183-30-4352 July31 , 1937 Pennsylvania Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 23s or 28s-4 show lunportant: If item 27 is marked ofther than "natural", or items 23s or 28s-4 show any injury or other traumatic event, it. Musical Exv., in a cuttal to mitting the second. 1 □Yes 2X No Director Harford Fallston Maryland 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 2203 Brookhaven Court 21047 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1X Yes 2 □ No
If Yes, Give Black, White, etc 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Liason Officer U.S. Marine Corp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Kupets, Sr. Mary M. Karpus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen C. Kupets 2203Brookhaven Court, Fallston, Maryland21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date W Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 1-29-09 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee michael ! 6009 Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to r as a consequence of): Bes pira 4 days disease or condition resulting in death) /Medical Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Cancer ung 6 months burial-trar Due to (or as a consequence of): physician a P.O. Box 68760, pe Physician/Medical phy Sema as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy o Month Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) □Yes 2□No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 □Yes 1 ☐Yes 2 ☐ No 2 L No 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 INTO 1 Impatient 2 ER/Outpatient 3 DOA မ funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

9000 Franklin 32. Registrar's Signatur

29c. License number

vare Drive Baltimore

29d. Date signed (Month, Day, Year)

#### Plea

			C	ertificate o	f Death	Re	g. No.	00	0001
1. Decedent's Nam	e (First, Middle	e, Last)				2. Date of Death Month	Day	Year	3. Time of Death
Lillian k	Kenney					11	30	2008	7 am
la Facility Name (I	f not institution	n, give street and num	ber)		4b. City, Town, or I	Location of Deeth	4c. Coun	ty of Death	
FROSTBURG	G NURSI	NG CENTER	FROSTBURG	VTLLAGE	FROSTBURG	G	ALLE	GANY	
. Social Security N	lumber	6. Sex 7	. Age (In yrs. last birthd	Months Day		8. Date of Birth (Month, Day,			place (State or Fore
214-07-24		ILIWI ZIZAF	91 Yrs			03 17 1	917		YLAND
Jsual Residence of 0a. State	10b. County		10c. City, Town or	Location				1	IOd. Inside City Limi
MD	ATTEC	1 4 B 7 5 7	EDOCEDIA	•					1 Yes 2□N
MD l0e. Street end Nur	ALLEC	SANY	FROSTBUR	10f. Zip Code		10	g. Citizen of	What Cour	ntry?
	IN STRE	יבירי							-
1. Marital Status	TH STRE		lent Ever in U,S. 1	21532 3. Was Decedent of	f Hispanic Origin? (S	pecify Yes or No-	JN LTED 14. Ra	STATI ace - Americ	
1 ☐ Never Marri	ied 2□ Marr	Armed Ford	es?	If Yes, specify C	uban, Mexican, Puert	o Rican, etc.)		ack, White,	
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/0	15. Decedent			cedent's Usual Occ		deine 1	6b. Kind of I	1147	
Elementary/Seco		st grade completed) College (1-4	life	e. DO NOT use ret	ne during most of wor red)	king			
12	, ,			OMEMAKER			OWN I	HOME	
7. Father's Name	(First, Middle,	Last)			18. Mother's Nan	ne (First, Middle, M	laiden Surna	me)	
JOSEPH EI	RICK				AGNES T	HOMPSON - E	LRICK		
19a. Informant's Na	ame/Relations	hip (Type, Print)	19b. M	ailing Address (Stre	et and Number or Ru	ral Route Number,	City or Town	n, State, Zip	Code)
TERI CL		DAUGHTER			EN UWY SW	CRESAPIC	WN, MI	2150	)2
0a. Method of Disp 1 X Burial 2 I 4 ☐ Donation	☐ Cremation	3 □Removal from Si pecify)	tatecemetery, c	sposition (Name of Frematory or other p HAEL CEME		Date 2 12-3-2008	Oc. Lócation	•	
21. Signature of Fu	neral Service I	Sowers	M00547	22. Name and Add	ress of Facility SOU IN STREET	WERS FUNE			
≥3a. Part 1. Enter the shock, or hea	ne disease, or rt failure. List	only one cause on ea		enter the mode of d	ying, such as cardiac				Approximate Interval Between Onset and Death
mmediate Cause ( disease or conditio resulting in death)		a. Ac	dvanced	deme	entia				6 months
			Due to (or as a con	sequence of):					
Sequentially list con f any, leading to im	nditions,	<b>f</b> b	Due to (or as a con-	sequence of):				1	
cause. Enter Unde Cause (Disease or hat initiated events	rlying injury	с							
esulting in death) L			Due to (or as a cons	equence of):				1	
lart II. Other eignif	icent conditio	no contribution to do	th but not resulting in the		river in Dest i	22h Dident			the cause of deat
art II. Ollor olgilir	- Onano	no contributing to dea	ar bat not resulting in the	dilderlying dadge i	given in reiti.	1 □ Ye		3 ☐ Prot	
	-					24a. Was an perform	autopsy ed?	ava	ere autopsy findings ailable prior to mpletion of cause death?
						1 □ Yes	2 No	10	]Yes ≱ No
5. Was case referrexaminer?	red to medical				26. Plece of Dea	th (Check only one	)		
1 ☐ Yes 2	No	Hospital: 1 ☐ Ing	oatient 2 ER/Outpat	ient 3 DOA	Other: Nursing H	ome 5 🗆 Resider	nce 6 □Ot	her (Specif)	y)
7. Manner of Deeth  1 Natural  2 Accident	n 5 □ Pending investig	9 '	Injury 28b. Time Day Year) Injur	/ W		28d. Describe how			
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	ot be 28e. Place o	f Injury - At home, farm, , etc. (Specify)	street, factory, offic	е	28f. Location (Stre City or Town,	eet and Num	ber or Rura	l Route Number,

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liqury or other traumatic event, if Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0020

**Physician** 

Examiner

**Funeral** Director

/Medical

29a. Certifier (Check only

Director

Funeral

þ

Completed

Be (

Physician/Medical Examiner

Be Completed by

Certification: To

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Division of Vital Records, P.O. Box 68760,

Registrar

WONSOCK SHIN MD State

29b. Signature and title of certifier worsockshir 29c. License number

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

MD21502

00055325

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 BISHOP WALSH RD Camberland

31. Date filed (Month, Day, Year) DEC 0 5 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State State	of Maryland / C				Mental Hy	giene			
		_	Registrar  1. Decedent's Name (First, Middle, Last)		Certiii	cate of L	Jeam	2. Date of De	Reg. No.	2111	18_	3. Time of Death
	Physicia		Gloria Jean	Kimble				Novemb	Day	3, 20	′ear ∩8	10:25 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and r	umber)	4b.	City, Town, or	Location of Dea			County of		10.23 1
**			7811 DeForest Drive				ake Bea			Calve		
	Funeral		5. Social Security Number 6. Sex 1 □ M 2 🏋 F	7. Age (In yrs. last birt		Jnder 1 Year Inths Days	If Under 24 Hi Hours Min		av. Year)		Birthp Coun	lace (State or Foreign
6	Director		214-52-2889 Usual Residence of Decedent	02				12/13/	1943		wası.	ington, DC
	ırylanı Show	Į.	10a. State 10b. County	10c. City, Town	or Locatio	n					10	Od. Inside City Limits
	he Ma 28a-f	Director	MD Charles	Wal	ldorf	of, Zip Code		- 1	10 000	£ 3.4.0		1 □ Yes 2 💢 No
	with t	Dir	10e. Street and Number 12820 Thompson Drive		1"	71. 21p Code 2060	<b>n</b> 2		rog. Citi	zen of Wh		.ry r
	death	Funeral	11 Marital Status 12. Was De	cedent Ever in U.S.	13. Was			(Specify Yes or No erto Rican, etc.)	)-	14. Race	Americ	
2-003b	within 72 hours after death with the Maryland sjere. Than "natural" or items 23a or 28a-f show than "had all a show the "had a show the marklest Evan in the restified at	by	1 Married 2 Married 1 Pyes 3 Widowed 4 Divorced Armed Armed 1 Pyes If Yes, 6 Year or	2 No Sive	l _	es 2 No	Specify:	erto Hican, etc.)		Black, Specify:	White, 6	white
ဂ ဂ	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed	16a.	(Give kind	S Usual Occupa	urina most of w	orkina	16b. Ki	nd of Busi	ness/Ind	ustry
7	filed within Hygiene. Ither than "	du		(1-4or 5+)	life. DO N	<i>OT use retired)</i> ng aide			ena.	rial	educ	cation
D D	e filed v al Hygie other i vent, III	ပ္	17. Father's Name (First, Middle, Last)		eachi		18. Mother's N	ame (First, Middle				.401011
yland	lid be Aental rked c	To Be	Joseph Carter Kim	ble, Sr.			Anna	Eliza	beth	Gr	ant	
Mary	2 shou and In is ma auma		19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Ad	dress (Street a	nd Number or	Rural Route Numb	er, City o	r Town, S	tate, Zip	Code)
≥ ຜົ	l and lealth sm 27 ther tr		Anna E. Kimble, Mother					Waldorf	·			Charles Charles
0	ages 1 nt of h t: If ite / or ol		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	n State I		(Name of y or other place		Date		cation - C		
Baltimor	nit. Pi artme ortani injury	-	4 ☐Donation 5 ☐ Other (Specify)	Cedar			ry 11/ s of Facility D	ausch Fui		land	•	
ñ	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 is marked other it any injury or other traumatic event, Its once.	6 9	Duyan 1 Nel	sach	832	25 Mt. I	Harmony	Lane, O	wings	, MD	e, r 20	736
		- 10 0	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final)	each line.					ırrest,			Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	Metasta o (or as a consequence o	_	Color	<u> </u>	inar				Months
	Examiner		Sequentially list conditions b.	HTN							1	Kews
	isit isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a conse pence o		10.						Ye o
,	execunation and all-trans	Exan	that initiated events c.	o (or as a consequence of	of):	demic	<b>^</b>					1-43
04/8	ite be iysicia ne buri	edical Examiner	d	Dial	ete?	>						Teurs
9	ertifica ling ph		IF FEMALE:							-		
ם פס	attend attend for us	Physician/M	in the past 12 months?	utcome of pregnancy birth 2  Fetal death gnant at time of death		opic pregnancy er (specify)			1	23d. Date Mont		ry Day Year
5	the di	ysic	1 Yes 2 No 4 Pre 9 Unknown 9 Un		5 LI O(I)	er (specify)						
ν, Γ	is that gned b	by P	Part II. Other significant conditions contributing to			ying cause give	n in Part I.	23e. Did t	obacco u	se contrib	ute to th	e cause of death?
	equire sen sig ould b		Anoxic Brain	1 Dama	ge.			1 🗆	Yes 2	No 3	☐ Prob	ably 4 🗌 Unknown
Vital Records,	has b	Completed		•				24a. Was auto	psy	pri	or to cor	osy findings available npletion of cause of
<u>a</u>	n: Ine ficate r, pag							1 □ Yes			ath? ]Yes	2 🗆 No
<b>=</b> :	/sicial s certi lirecto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 15	 Inpatient 2 ☐ ER/Out	tnationt 3	Othe		Home 5 Resi		Othor	(0	
VISION OF	ter thi	on: To	27. Manner of Death 28a. Da	e of Injury 28b. T	Time of	28c. Injury Work		28d. Describe				7
S :	eath. or: Al	catic	2 Accident investigation		<i>N</i>	1 □ Y	es 2□No					
<u> </u>	safter of all Direct	Certification:	4 Homicide determined 28e. Pla	ce of Injury - At home, far ding, etc. <i>(Sp</i> ec <i>ify)</i>	rm, street, f	actory, office		28f. Location ( City or To	Street an wn, State,	d Number	or Rura	l Route Number,
	To the rospital or Attending Priysician: The law requires that the death certificate be executed within 24 board after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (	29a. Certifier 1 Certifying Physiclan: To t (Check only one) Check only one) 1 Certifying Physiclan: To t 2 Medical Examiner: On the and ma	ne best of my knowledge basis of examination and unner stated.	e, death occ d/or investi	urred at the tim gation, in my op	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s)	and man place, an	ner as st d due to	ated. the cause(s)
ř	withir To th comp	Me	29b. Signature and title of certifier			29c. License	number			,		Day, Year)
	3		1 Kolotub am	Mym	10	Door	1047	9	(1)	141	05	7
(	W		30. Name and address of person who completed ca				1	,	) -			C
	Sta	te	31. Date filed (Month, Day, Year) 22.	Registrar's Signature	120	210 010	1 Line	enter su	te 10	U Wa	alda	rf MO 26603
	Registra		NOV 1 7 2008	M. Ana	100							

Registrar
DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 26

istrar's Signature

32. F

			For State of N	laryland.	-	artment of H rtificate of L	lealth and M Death		jiene _{eg. No} 2 N N 8	38971
		z č	Decedent's Name (First, Middle, Last)			timodio oi i	Journ	2. Date of Dea	th	3. Time of Death
h	Physici /Medic		William Francis Kelmart:	in				Month November	er 15 200	3.4
	Examin		4a. Facility Name (If not institution, give street and numbe	r)		4b. City, Town, or	Location of Death		4c. County of Dea	
K			Carroll Hospice Dove House	<b>3</b>			minster_		Carro	11
1000	Funeral Director		213-30-0990 ¹ ⊠ ^{M 2□ F}	Age (In yrs. last 75	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug 22	Year) C	rthplace (State or Foreign Country)
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits
	Mary -f sho ied a	호	MD Carroll	F	inksk	oura				1 □Yes 2 No
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	h witl	a D	1900 Welsh Ct.			210	48		USA	
	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	11. Marital Status  12. Was Deceder Armed Forces  1 □ Never Married 2 Married  12. Was Deceder Armed Forces	3?	13. Y	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
Maryland 21215-0036	urs af al", or Exam	b	1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ If Yes, Give Year or Dates	1		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
Ö	72 hol	Completed	15. Decedent's Education (Specify only highest grade completed)	1	16a. Dece	lent's Usual Occupa	ation	pa l	16b. Kind of Business	
2	ithin 7 ne. nan ".	nple	Elementary/Secondary (0-12) College (1-40)	r 5+)			during most of worki	1	Social S	
2	led w lygier her th	Š	12		Sur	ply Syste	ems Analy		Administ	ration
anc	l be fi ntal ⊦ <b>ed ot</b> ever	To Be	17. Father's Name (First, Middle, Last)  Thomas Patrick Kelmartin				18. Mother's Name		viaiden Surname)	
Š	hould id Me mark matic	ř	19a. Informant's Name/Relationship (Type. Print)		19h Mailir	n Address (Street a			r, City or Town, State,	Zin Code)
	nd 2 s lith ar 27 is rtrau		Constance Kelmartin/wife			) Welsh C		burg, M		Zip Gode)
ē,	s 1 ar of Hea item		20a. Method of Disposition	20b. Plac		sition (Name of natory or other place			20c. Location - City o	r Town, State
Ë	Page rent o nt: If		1 ☐ Burial 2 【Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)			remation,		'	Hampstead,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ı	21. Signature of Funeral Service Licensee	1					apel, P.A. inster, MD	21157
-			23a. P. rt1. Em. r the disease, or prications that caus shock, or heart failure. List only one cause on each	ed the death. I						21157 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(	ncer					Onset and Death
	/Medical Examiner		resulting in death)  Due to (or a	consequen	ice of):					
	0	er	Sequentially list conditions, if any, leading to immediate cause Enter Under In Cause (Disease or injury	s a consequen	ice of):					
	uted d ansit	Examiner	cause Enter Under In Cause (Disease or injury that initiated events							
oʻ	icate be executed physician and s the burial-transit	Еха		s a consequen	ice of):				<del></del>	
68760	ate be nysicia he bu	edical	d							
	e as t	Med	IF FEMALE:							1
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant 1 Live birth	2 Fetal de	eath 3	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
P. O.	the de	ysic	1  Yes 2 No 4 Pregnant 9  Unknown 9 Unknown	at time of deat	n 5∟	Other (specify)				
J.	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death	but not resultir	ng in the ui	nderlying cause give	en in Part I.	23e. Did tol	pacco use contribute t	to the cause of death?
Vital Records,	quire: en sig uld be	ed by						1 <u>1</u> <u>7</u>	≨s 2 □ No 3 □ F	Probably 4 □Unknown
ပ္က	aw re	Completed						24a. Was a	n 24b. Were a	utopsy findings available
ř	Physician: The lav this certificate has al director, page 2	mo:						autops perform 1 Yes	med? death?	
/ita	clan: ertific ector,	Bec	25. Was case referred to medical examiner?				26. Place of Death	157	T	
	physic this c	ပ္	1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpa	tient 2 ER			4 LI Nursing Ho		ence 6 DiOther (Sp	ecify) Dove Hacus
Division or	ttending Phy Jeath. :tor: After thi the funeral o	ion:	27. Manper of Death  1 Matural  5 □ Pending  (Month, Death of Inc.)		3b. Time of Injury	Work		28d. Describe ho	ow injury occurred	
S	death death ctor: y the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of it	niury - At home	e. farm. str	eet, factory, office	Yes 2 □ No	98f Location (St	reet and Number or F	Rural Route Number
2	after d Direct d in by	Certification:		etc. (Specify)	,	,,	1	City or Towi	n, State)	and Hodie Humber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.		29a. Certifier  (Check only   Certifying Physician: To the best   Check only   Certifying Physician: To the basis	of examination	dge, death and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the c ed at the time, d	ause(s) and manner a late and place, and du	is stated. ie to the cause(s)
	o the ithin 2 o the omple	Medical	one) and manner s	stated.		29c. License	number	2	9d. Date signed (Mon	th, Day, Year)
	1.17-		Propert & Rain ma	Ohin		na	1020	)	11/12/	OCT.
,	O-HIVA		30. Name and address of person who completed cause of	death (Item 23	Ba) (Type,	Print) Robert	L. Rice	MD	111174	
[	ווט		Alliance Hematology	oncolo	ai	555 S.(	Center St		ninster. L	10 21157
	Sta	_		tran's Signature	Rea	1 10		,		
	Registr	ar	NOV 1 8 2008	Alver 1	J. A	HOBALIS				

			For	State of Maryla	-			d Mental Hy	giene	Ja 19
			State Registrar		Cei	rtificate of	Death		Reg. No 2 U U 8	389/5
п	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	Day Year	3. Time of Death
4	/Medic	al		LOLLER					er 30 200	
	Examin	er	4a. Facility Name (If not institution, give Union Hospital	street and number)		Elktor	or Location of De	eatn	4c. County of Dea	ım
• 0.1	Funera!		Social Security Number 6. Sep.		. last birthday)	If Under 1 Year	If Under 24 F	rs. 8. Date of Birt		thplace (State or Foreign ountry)
	Director		214-72-9495	M 2⊠F 90	Yrs.	Months Days	Hours M	lin. (Month, Da Dec 31		ountry) aryland
	pu ,		Usual Residence of Decedent							
	arylai show	'n	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	he M	Director	MD Cecil  10e. Street and Number	Ce	ciltor	10f. Zip Code			10g. Citizen of What C	
	with t	اق	328 Crystal Bea	ach Bd			2			ountry?
	leath	Funeral		12. Was Decedent Ever in U	J.S. 13. V	2191 Was Decedent of		(Specify Yes or No Juerto Rican, etc.)	U.S.A. - 14. Race - Am	erican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is involved Exacilism invariates a calification once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		fYes, specify Cub I∐Yes 2 <b>⊠</b> No		uerto Rican, etc.)		e, etc. White
5-0036	2 hour	led I	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Business	/Industry
215	hin 72 9. an "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. I	kind of work done DO NOT use retire	e during most of ved)	working		•
2121	d with	Son	7		Hon	emaker			Own Hom	e
nd	be file d oth event	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,	<i>'</i>	
<u>X</u>	Men Marken Marken Marken	으	John Wolfe						ca Rhodes	
Mafyland	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (Ty John W. Loller			-			er, City or Town, State, Earlevill	zip Code) e, MD 2191
	1 and Heal tem 2		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	;	Date	20c. Location - City or	
ē	ages ent of ht: #f ii 'y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donatign 5 ☐ Other (Specify)			natory or other pla		12/4/08	Earlevil	le Mn
Baltimore,	mit. F partm portar / inju		21. Signature of Funeral Service License							L Schaech
Ď	permi Depar Impor any ir			M00:	510 11	8 West	Cross	St. Gal	ena, MD.	L Schaech 21635
			23a. Part 1. Enter the disease, or complishock, or hear failure. List only or	cations that caused the dea	th. Do not ent	er the mode of dy	ring, such as card	diac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Serve	ne i	Aarti	c St.	enusis		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	1)	U	. 1		
		<u>-</u>	Sequentially list conditions,	Due to (or as a consec	nuence of):	Hyp	071	Troid.	SM	
х,	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2 - 2 - 12 (0, - 12 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	,	ι ·				
o O	an an rial-tr		resulting in death) Last	Due to (or as a consec	quence of):		<del></del>			
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		l						
_	ertific ling p e as t	Med	IF FEMALE:					···		
Box	leath certific attending p for use as t	Physician/M	in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	Ectopic pregnan	су		23d. Date of de Month	livery Day Year
o'	at the de by the a	ysic	1 □Yes 2 <del>2 No</del> 9 □ Unknown	9 ☐ Unknown	death 5L	Other (specify)				
J.	res that signed b be deta		Part II. Other significant conditions con	tributing to death but not res	sulting in the ur	nderlying cause gi	ven in Part I.	23e. Did to	obacco use contribute t	the cause of death?
Vital Records,	quires en sig uld be	ed by						_ 1 🗆 ١	∕es 2 No 3 P	robably 4 Unknown
ပ္တ	aw requir is been s 2 should	plete						24a. Was		utopsy findings available
ř		Completed						— autop perfo 1 □ Yes	rmed? death? 2.25No 1 □ Yes	completion of cause of
Ħ	ctor,	Be	25. Was case referred to medical examiner?					Death (Check only o		
	Physician: r this certific ral director, p		1 □ Yes 2 □	lospital: 1 Inpatient 2		1 3 DOA			dence 6 ☐ Other (Spe	ecify)
Division of	ding h. After fune	Certification: To	27. Manner of Death  1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Inju Wo M 1 T	uryat irk? ⊒Yes 2 ⊒ No	28d. Describe h	now injury occurred	
ISI/	r Attending er death. rector: After by the funer	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, str			28f. Location (S	Street and Number or R	ural Route Number,
ā	e Hospital or Atten 24 hours after deat 9 Funeral Director: etely filled in by the		4   Hornicide	building, etc. (Spec				City or Tou		
	e Hospital or 24 hours afte e Funeral Dir letely filled in	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or in	occurred at the treatment occurred at the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of the treatment of th	time, date and pl opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the I Complet	Me	29b. Signature and little of certifier			29c. Licen	se number		29d. Date signed (Moni	th, Dalv, Year)
			Mal -	5	_ ~	OP	0054	449	11/32	107
	(5)		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print)	1 -	101	~	-11-1 2192
	10		Olaria Dime		M) II	I.W.H.	gho	+ Duit	C 302 E	KtarMD
	Sta Registra		31. Date filed (Month, Day, Year) DEC 0 5 2008	32. Registrar's Sign	TOPAS L		l			

			For State Registrar		State of I	Marylan		artment of F rtificate of I				iene eg, No.	308	38976
			1. Decedent's Name (Firs	t, Middle, Las	st)						Date of Dear	th		3. Time of Death
	Physicia /Medic				Ri Anh Lu	ong				N	Month November	Day 2r 17	Year 2008	9:20 A ^M
	Examin		4a. Facility Name (If not in	nstitution, giv	e street and numb	er)		4b. City, Town, or	r Location		, , , ,		nty of Death	7 2 2 2 2 2
A.			18 Farmo						er Spr					gomery
	Funeral		5. Social Security Number	1	ex 7. ☑ M 2□ F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours		Date of Birth (Month, Day		Cou	
	Director		577-02-5628 Usual Residence of Dece	3		68				S	eptembe:	r 5,194	0	Vietnam
	ow M			County		10c. City	, Town or Lo	cation					1.	10d. Inside City Limits
	Many a-fsh	ģ	Maryland	Montg	omery			Sil	ver S	pring				1 □Yes 2 No
	or 28s	Director	10e. Street and Number					10f. Zip Code		1	1	0g. Citizen	of What Cou	ntry?
	th wit	a a	18 Farmo	rest Co	ırt				2090	5			U.S	.A.
	r dea	Funeral	11. Marital Status		12. Was Decede Armed Force	nt Ever in U.Ses?	3. 13.	Was Decedent of H	lispanic O an, Mexica	rigin? (Specifi an, Puerto Ric	y Yes or No- an, etc.)		Race - Ameri Black, White,	
36	s afte	by Fi	1 Never Married 2		1 ∐Yes 2 If Yes, Give			1 ☐ Yes 2 ☒ No	Specify				ecify:	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show licel Examinat to positive an	q pa	3 ☐ Widowed 4 ☐ C	Divorced Decedent's Ed	Year or Date	es:	16a Dece	dent's Usual Occup	ation			16h Kind o	f Business/In	Asian
15	in 72 n "na"	plet	(Specify on	ly highest gra	de completed)		(Give	kind of work done of DO NOT use retired	during mo	st of working		rop. rand o	, Daoineouvin	doory
212	with giene r tha	Completed	Elementary/Secondary 12	(0-12)	College (1-4d	or 5+)		Entrepre	eneur			C	Clothing	Store
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, It a Modical Examinet must be rediffed at	Be C	17. Father's Name (First,	Middle, Last)					18. Moth	her's Name <i>(F</i>	irst, Middle, I	Maiden Surr	name)	
/lai	uld be Menta	To	Du My Lu	ong							Chi Tho	ai Tran	1	
Maryland	2 sho and I Is ma		19a. Informant's Name/R	lelationship (	Type. Print)		19b. Mailir	ng Address (Street	and Numi	ber or Rural R	loute Numbe	r, City or To	wn, State, Zij	o Code)
≥,	and and m 27		Kenneth L		Brother		1	0 Rippling						
ore	ges 1 t of H If ite or otl		20a. Method of Dispositio		Removal from Sta	ate 20b. P	lace of Dispo emetery, crei	sition (Name of natory or other plac	ce)	Date	•	20c. Locatio	on - City or To	own, State
Baltimore,	t. Pag tmen tant: ijury		4 □ Donation 5 □ C			Ga		eaven Cemet	-		the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon			Maryland
Bal	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral	ervice Lice	see tee	7								Home, Inc. g,MD 20904
			23a. Part 1. Enter the disc shock, or heart failu				. Do not ent	er the mode of dyir	ng, such a	as cardiac or re	espiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			carcinom	a of th	e Colon						Onset and Death 3 months
	/Medical Examiner		resulting in death)		Due to (or	as a consequ	ence of):							
	Examine	<u>_</u>	Sequentially list condition	ns,	b		6							
	ted nsit	nine	Sequentially list condition if any, leading to immedia Cause (Disease or injury that initiated events	ate	Due to (or	as a consequ	ence or).						-	
ב	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last		c Due to (or	as a consequ	ence of):							
68760,	te be ysicia e buri	edical			d									
	rtifica ng phr as th	fedi											1	
Вох	eath certific attending p for use as t	an/N	tF FEMALE: 23b. Was decedent pregr		23c. If yes, outcom	me of pregna th 2 ☐ Fetal		Ectopic pregnanc	v			23d.	Date of deliv	
O. E	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ns?		nt at time of d		Other (specify)					Month	Day Year
9.	uires that the de signed by the a d be detached f	Phy	Part II. Other significant	conditions	ontributing to deat	h hut not racu	lting in the u	nderlying cause giv	an in Part		23e Did to	hacco use c	ontribute to t	he cause of death?
of Vital Records,	ires ti signe	by	Tarris other signmeant	oonamons c	onanbuting to dout	T But Hot 1000	itang ar are a	noonying oddoo giv	on arr arr					bably 4 ☐ Unknown
Ö	w requir s been s should I	Completed						<del></del>						
Rec	he law has ge 2 s	mpl									24a. Was a autops perfori	sv l	prior to co death?	opsy findings available ompletion of cause of
la.	i <b>cian:</b> The l certificate ha ector, page		25. Was case referred to	modical				<del></del>			1 ☐ Yes	2 🖾 No	1 ☐ Yes	2 □No
Ξ	ystcia is certi directc	) Be	examiner?  1 Yes 2 No	medicai	Hospital:	atient 2	ER/Outpation	ot 3 🗆 DOA Oth		ce of Death (C Nursing Home	· · · · · ·		Othor (Cara	£ A
ō	<del>5</del> + = =	ü	27. Manner of Death		28a. Date of	Injury	28b. Time o				f. Describe h			(y)
ion	nding F ath. r: After e funera	atio	1 X Natural 5 ☐ 2 ☐ Accident	Pending investigation		Day, Year)	Injury		k? Yes 2□	□No				
Division	l or Attencafter death Director:	iitic	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e, Place of	Injury - At ho , etc. (Specif)	me, farm, str	eet, factory, office		28f.	Location (S		ımber or Run	al Route Number,
	tal or rs after al Direction	Certification: To	Temode		- Januari 9						Only or Your	i, ciarc)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical				is of examina		h occurred at the til vestigation, in my c						
	To the within To the Somple	Me	29b. Signature and title of	f certifier	1	. 3		29c. Licens	e number		2	.9d. Date sig	gned (Month,	Day, Year)
	1		•	F	The	MD		D5	448	76		NOVE	MBER	18, 2008
	T		30. Name and address of	f person who	completed cause	of death (Item	23a) (Type,	Print)						
								enue, Suite	e #310	, Takoma	Park,	Marylar	nd 20912	
	Sta		31. Date filed (Month, Da		200	istrar's Signat		a. 8.	-					
	Registr	ar	VON	1 9 20	UO DE	was de	199	NOW!						

		for State Registrar		State	of Marylan	_	artment of F ertificate of t		Mental Hy	/giene -Reg. No	008	38977
Physi	cian	1. Decedent's Nam Leon Ja			2		-		2. Date of Do Month	Day	Year	3. Time of Death
/Med	dical	4a. Facility Name (		ofthus,			4b. City, Town, or	Logotion of Dec			L7, 200	
Exam	iner			Nursing 8	•		Rockville		itn		County of Dea Iontgom	
Funera	al	5. Social Security N		6. Sex	7. Age (In yrs.	last birthday	1	If Under 24 Hr Hours Mir		rth		thplace (State or Foreign ountry)
Directo	r	387-16-		1 <b>3</b> M 2 □ F	90	Yrs.	Widitiis Days	Tiours IVIII	July 2			nnesota
land ow		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits
Mary I-f sho	ģ	Maryland		Montgor	nerv	Rocky	ille					1 □Yes 2 <b>K</b> No
h the	Director	10e. Street and Nu	mber			-100121	10f. Zip Code			10g. Cîtiz	en of What Co	ountry?
th wit			Jasmine	Drive			20853				USA	
yidilia 4 14 13-0030  uld be filed within 72 hours after death with the Maryland Mental Hygiene.  arked other than "natural", or items 23a or 28a-f show atte event, I'm Medical Exercitive intal be neithed at	Funeral	11. Marital Status		Armed		S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	0- 1	4. Race - Ame Black, White	
rs afte	bv F			ed 1 TxYes If Yes, 0 Year or	s 2 □ No 3ive Dates: <b>WW</b>	тт	1 ∐Yes 2√2√No	Specify:			Specify:	1-4
2 hour			15. Decedent	's Education		16a. Dece	edent's Usual Occup	ation		16b. Kin	d of Business	hite /Industry
6. thin 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "him 7. and "hi	Completed	Elementary/Seco		t grade completed	(1-4or 5+)	(Give	e kind of work done o DO NOT use retired	durina most of wo	orking	1/1		
ed wit ygien ber th	5	·			1	Na	val Weapo				Navy	
be fij	Be	07-5-7-	(First, Middle, I hn Loft	,					me (First, Middle		lurname)	
lal ylallu Z IZ 2 should be filed within and Mental Hygiene. is marked other than aumatic event, Ix	P	19a. Informant's N				10h Mail	ing Address (Street		oss V. B		Taura Otata	7:- 0:- 1:)
ite, INIAI yIAIIIQ ZIZIO-UUOO s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its Medical Exeminari, and be notified at				thus, Jr	./ Son	190. Wall	18635 O1			-		•
item		20a. Method of Dis				lace of Disp	osition (Name of matory or other place	a)	Date	20c. Loc	ation - City or	Town, State
Page nent c			☐ Cremation 5 ☐ Other (Sp	3 □ Removal from Decify)	n State		Memorial	DI- No	ov. 21, 2008	01n	ey, Ma	rvland
permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other tran	olice.	21. Signature of Fi	uneral Service I	Licensee		E E	2. Name and Address J.	ss of Facility Collin	s Funera	1 Hom	e Inc.	
		23a. Part 1. Enter	the disease, or	complications that	caused the deat		ter the mode of dyin				r spri	ng, MD 20901 Approximate
Physiciar	ŧ.	Immediate Cause	(Final	only one cause on	each line.	ation	one	lina can	10		10	Interval Between Onset and Death
/Medica	ı	disease or condition resulting in death)	эn S	a	o (or as a consequ	uence of):	7 11.0	yman				
Examine		Sequentially list co	nditions	b								
ed sit	Examiner	cause. Enter Under	erlying	206.5	o (or as a consequ	venne of):						
xecut and	хап	Cause (Disease or that initiated event resulting in death)	s	c	o (or as a consequ	uence of):						
g physician and as the burial-transit					,	,.						
. ⇒ D, 6	ledical			0.								
eath cert attending for use a	Physician/M	IF FEMALE: 23b. Was deceden			utcome of pregna	incy	☐ Ectopic pregnancy	,		23	3d. Date of de	livery
e dea the at	sici	in the past 12	□No		gnant at time of d		Other (specify)	,			Month	Day Year
that the dended by the detached	Phy	9 Unknown		ns contributing to	death but not reci	ulting in the u	ınderlying cause give	an in Port I	23a Did	tobacco us	e contribute t	the cause of death?
<u> </u>	þ	S	1		dealir but not rest	along in the t	indenying cause give	miraiti.		Yes 2		robably 4 Unknown
w requir	Completed		,						24a, Was	an	24h Ware a	utopsy findings available
The lav	l di								auto	psy ormed?	prior to death?	completion of cause of
ian; The	نه ا	25. Was case refer	red to medical					26. Place of De	1 ☐ Yes eath (Check only		1 Ll Yes	2 <b>7</b> No
hysician; this certifica	To B	examiner? 1 ☐ Yes 2 🔀	No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DOA Othe		Home 5 ☐ Resi		Other (Spe	ecify)
ding Ph h. After th funeral		27. Manner of Deat	th 5 Pending		e of Injury onth, Day, Year)	28b. Time of Injury	Work		28d. Describe			
ttend death stor: /	cati	2 Accident 3 Suicide	investig 6 ☐ Could n	ation of he				Yes 2 □No				
or A after Direction by	Certification:	4 Homicide	determi	ned 28e. Plac buil	ding, etc. (Specify	me, tarm, st	reet, factory, office		City or To		Number or Ru	ural Route Number,
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun		29a. Certifier	1 ☑ Certifyin	g Physician: To th	ne best of my kno	wledge, dea	th occurred at the tin	ne, date and plac	ce, and due to the	cause(s)	and manner a	s stated.
he Ho in 24 I he Fu pletel	Medical	(Check only one)	2 Medical E	examiner: On the	basis of examina inner stated.	tion and/or i	nvestigation, in my o	pinion, death occ	curred at the time,	date and p	place, and due	e to the cause(s)
Vith Vom	Ž	29b. Signature and		1	~ A		29c. License				signed (Mont	/
1541		•	3) (		V 0'		100	6243.	5	1 {	[18/	2008
, , ,		30. Name and add	ess of person v	who completed can	use of death (Item	23a) (Type,	Print) Car A	Rose	- Kuill	CIN	11) 2	2008
S	tate	31. Date filed (Mon	th, Day, Year)	33	Registrar's Signar	ure (CE)	ant 8	v - , /\C\				0,00
Regis		A16	w 19	2008	we l	A Page						

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2008

3. Time of Death 10:20

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 🗆 No

Year

1 X Yes 2 □ No

Pennsylvania

A M

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7066 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D. Shah, M.D. 22650 Cedar Lane Court Leonardtown, MD 20650 31. Date filed (Month, Day, Year) 32. Revistrar's Signature State

Registrar

29a, Certifie

1 - For State Registra

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F ertificate of			Reg. No.	98	38979
	Physici /Medic		1. Decedent's Name (First, Middle, La	MARIE	LANDON			2. Date of Dea Month	ath Day	Year OB	3. Time of Death
	Examir		4a. Facility Name (If not institution, git Peninsula Regional	e street and number)	Centle		alis bucy			comic	
	Funeral Director			Sex 7. Ag 1 □ M 2√√√F	ge <i>(In yrs. last birthday</i> 80 ^{Yrs.}	Months Days	If Under 24 Hrs Hours Min		h y, <i>Year)</i> 6, 1928		lace (State or Foreign try) land
	Aaryland f show	or	10a. State 10b. County		10c. City, Town or L					10	0d. Inside City Limits 1 ☐ Yes 2√√No
	with the N 3a or 28a-	Funeral Director	Maryland Some 10e. Street and Number 4121 Jacksonville			Crisf 10f. Zip Code	ield 21817		10g. Citizen of \	What Coun	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at		11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 □ If Yes, Give Year or Dates:	Ever in U.S. 13.	. Was Decedent of H If Yes, specify Cub 1 □Yes 2 X No	Hispanic Origin? ( an, Mexican, Puer		14. Rac Blac Specify	ce - Americ ck, White, e	an Indian,
21215-0036	filed within 72 hor Hyglene. Ither than "natura ont, the Medical E	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	(Give	edent's Usual Occup e kind of work done DO NOT use retire Cafeteria Manager	during most of wo	rking	Cutler	V	,
/land	should be filed and Mental Hygi s marked other umatic event, tt	To Be C	17. Father's Name (First, Middle, Las  W. Washington Ty				18. Mother's Na	me (First, Middle, es Justi	Maiden Surnan		£
, Mar	1 and 2 sho Health and I tem 27 is ma other traums		19a. Informant's Name/Relationship Susan Smith (Dau	(Type. Print)		ing Address <i>(Street</i> Hammock F					,
=	permit. Pages 1 al Department of Her Important: If item any injury or othe once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State		osition (Name of ematory or other place Memorial I	i	Date 18, 200	20c. Location -	, , , , , ,	,
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Unieral Service Lice Robert H. Bra	ser,	2 1 12	22. Name and Addre	ess of Facility BR	ADSHAW &	SONS F	UNERA	
30	Physician		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	d the death. Do not er ine.	nter the mode of dyi	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner	iner	Sequentially list conditions, hary, leading to harnedlate cause. Enter Underlying Cause (Disease or injury that initiated events	b	a consequence of):	MI					~
68760,	ificate be executed g physician and st the burial-transit	edical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):						
	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		2 Fetal death 3	☐ Ectopic pregnand	cy			te of delive	ry Day Year
rds, P.	quires that in signed build be deta	þ	Part II. Other significant conditions	_	out not resulting in the	underlying cause giv	en in Part I.		obacco use cont ′es 2 ☐ No		e cause of death? ably 4 \( \square\) Unknown
of Vital Records,	: The law requir cate has been s , page 2 should	Completed	H7	M (0.					rmęd?	prior to cor death?	osy findings available npletion of cause of
	ysician: nis certifica director, p	To Be C	25. Was case referred to medical examiner?	Hospital: 1 Inpati	ent 2 ☐ ER/Outpatio	ent 3 DOA Oth	or:	ath <i>(Check only o</i>	ne)		
ivision	or Attending after death. Director: Afte in by the fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to determine to	28e. Pl. ce of In building, el	jury - At home, farm, stc. (Specify)	Wor 1 □	ryat k? ]Yes 2.∭SXNo	Fall 28f. Location (S City or Ton	vn, State)	per or Rura	Route Number,
	Hospital 24 hours a Funeral I etely filled	edical C			of my knowledge, dea of examination and/or i			e, and due to the			
	To the within 2 To the comple	Me	29b. Signature and little of pertifier			29c. Licens	0497		29d. Date signe	8	
10	L EB		30. Name and address of person who	IdER DO	death (Item 23a) (Type	Print)	t, SAL	sbury 1	nd 2	180	/
	Sta		31. Date filed (Month, Day, Year) 1	2008 32. R gist	rar's Signature	1					

DHMH 17 Rev 1/2001

Medica

08-08911 Charles Lehman	1		or Print in Bla of Maryland /	Depar		Health	n and		ygiene	200	3 3 3 9 3
Physiciar	_	Registrar 1. Decedent's Name (First, Middle,La	st)	00/1/	noute or	Douin			Re 2. Date of Death	g. <b>N</b> o.	3. Time of Death
Medical Examin		Charles	Michael	1	.ehman	1			Month November	Day Year 27, 2008	1208 hrs
	-	4a. Facility Name (if not institution, gi					wn, or Le	ocation of Death		4c. County of Death	Park
		Western Maryland Health	System			Cumbe	erland			Allegany	
Funeral Director		5. Social Security Number 6. \$ 213-90-0583	Sex 7. Age	(In yrs. las	t birthday) Yrs.	If Under Months		If Under 24Hrs Hours Min	_	1961 Foreig	
<b>&gt;</b>	F	Usual Residence of Decedent  10a. State 10b. County		Oc City T	own or Location	on		_			10d. Inside City Limits
ow any	1	10a. State 10b. County Alle	gany  ˈ	oc. Oity, 1	own or Location	iberla	nd				1 X Yes 2 No
-f she	2								110	g. Citizen of What Cou	
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmatic event, the Medical Examiner must be notified at once.	II Director	10e. Street and Number 123 S. Allegany				10f. Zip C		21502		US	٩
th wir	Funeral	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent E Armed Forces?	ver in U.S				anic Origin? ( Sp Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
or dea	[]		1 Yes 2'	No		Yes 2 X	( ) No.			Specify: whi	te l
rs afte	⋧┞	3 Widowed 4 Divorce  15. Decedent's Education (Specify	If Yes, Give Year or Dates:	leted)				on (Give kind of v	work done	16b. Kind of Business/	Industry
"natı	ᇍ	Elementary/Secondary (0-12)	College (1-4 or 5-	·				DO NOT use reti			
36 hin 72 e. than dical	ᇍ	12	0011090 (1 1 0.1 0	1	Electi	rician				Gill-Simp	son
215-00 e filed wit al Hygien ted other nt, the Me	Be Completed	17. Father's Name (First, Middle, Las Charles, Irvin	Jr.				18	8.Mother's Name	First, Middle, N	Maiden Surname) Lehman	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mernal Hyggiene. Department of Health and Mernal Hyggiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		19a. Informant's Name/Relationship Lisa Lehrnan	(Type, Print ) Wife	<del>-</del>	19b. Mailing	Address S. A	(Street	and Number or I	Rural Route Num	ber, City or Town, State mberland	MD 21502
and and Health item	t	20a. Method of Disposition			ace of Disposi		e of cem	etery,	Date	20c. Location - City or	Town, State
DOF ages 1 nt of 1 t: 1	ı	1 X Burial 2 Cremation 3		C	ematory or oth /is Memo		amete	an/	11/30/200	8 Cumber	land MD
Itin	ŀ	4 Donation 5 Other Specifical Service Lice	nsee 2	Dav		ame and A					
Ba perm Depr Imp	- 1		////			0.		III Cumaral I	Home, PA		
Physician		23a Part I. Emjer tilledisease, or con failure. List only one cause of	plications that caused t	ne death. [	Do not enter th	ne mode of	J8 Vir dying, s	ginia Aveni uch as cardiac d	r respiratory arre	est, shock, or heart	Approximate Interval
/Medical	4	fafilure. Lest only one cause of	each line. a. Cardiac a	rrhyt	-hmia						Between Onset and Death
xaminer	-	Immédiate Cause (Final disease or condition resulting in death)	Due to (or as a consec								
	1	Sequentially list conditions,	Cardiomega	ly wi	ith lef	t ver	ntri	cular h	ypertrop	hy	
	힐	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consec	uence of):							
9	Examine	(Disease or injury that initiated	Due to (or as a consec	uence of):							
recuted .	Ĭ	events resulting in death) Last	1.	įdonoo or).							
execu	eg	X UNPENDED :	AMENDED PI	line	a-b, 2	27, pe	erME	, g886	12/11/08	TT	
60, ate be hysici e buri	Physician/Medica	IF FEMALE:	23c. If yes, outcome							23d. Date of deliver	
rtifice	֓֟֝֟֓֟֝֟֝ <u>֚֚</u>	23b. Was decedent pregnant in the past 12 months?	1 Live birth	р 5		tal death	3	Ectopic pregna	ancy		Day Year
or use	<u> </u>	1 Yes 2 No 9 Unknow	4 Pregnant at t	me of dea	th 5 Oth	ner (Specif	ify)				
he der	إخ		9 OHKHOWH	h				un in Dark I	220 Did to	bacco use contribute to	the sauce of death?
that the detack	2	Part II. Other significant conditions	contributing to death	but not res	suiting in the u	inaeriying c	cause giv	ven in Part I.			bably 4 V Unknown
S, F	8										
w req	Completed								24a. Was autop	sy prior to	utopsy findings available completion of cause of
GC The la ate hange 2	틹								1 <b>✓</b> Yes	rmed? death? 2 No 1 ✓ Y	es 2 No
an: Tantific ertific	οl	25. Was case referred to medical				26		of Death (Check	only one)		
Vite vites of I direct	e B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	t 2 🗸 E	ER/Outpatient	3 DO	DA C	Other Nursi	ng Home 5	Residence 6 Othe	er:
Of ng Pt After uneral	=	27. Manner of Death	28a. Date of Injur (Month, Day,Ye	y ar)	28b. Time of I	njury 28	8c. Injury	at Work?	28d. Describe h	now injury occurred	
ion tendi eath. the ft	(율	1 X Natural 5 Pending 2 Accident Investiga					1 Ye	es 2 No			
Division of Vital Records, P.O. Box 68760, so a Attending Physician: The law requires that the death certificate by an after death.  "I Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the bur	<u>≅</u>	3 Suicide 6 Could no	ot be 28e. Place of Inju	ry - At hor	ne, farm, stree	et, factory, o	office bu	ilding, etc.	28f. Location (S or Town, S		ural Route Number, City
Dital pital sours a eral I	Certification:	4 Homicide determin				_			or rown, s		
		29a. Certifier 1 Certifying Physic (Check only)	cian: To the best of my	knowled96	e, death occur	red at the t	time, dat	e and place, and	due to the caus	e(s) and manner as sta	ted.
Fo the complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete compl	Medical		er: On the basis of exam and manner stated.	ination and	d/or investigat				at the time, date		
	Σ	29b. Signature and title of certifier				29c.	License	number		29d. Date signed (Mo	onth, Day, Year)

0 State Registrar

31. Date filed (Month Day Year) 2008

Carol Allan, MD

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32 Registrar's Signature

O.C.M.E.

November 28, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 15,2008 Physician 3:10pm M Mangerian Charles /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Jan 17, 1924 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours Warren. MA 025-14-4350 84 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exp. in the structure of the process. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington 1 Yes 2 □ No DC Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20016 4301 Massachusetts Ave, N.W. #1014 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married _{Specify:} White 1 □Yes 2 🛣 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
Plate Maker Elementary/Secondary (0-12) 9ollege (1-4or 5+) Fed Govt 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Rose Mazmanian George Mangerian ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9721 Overlea Dr. Rockville, MD 20850 19a. Informant's Name/Relationship (Type. Print) Marion Paul/ Sister 20a. Method of Disposition 20c. Location - City or Town, State Date Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-20-2008 Rockville, MD Parklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Funeral Service License 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eveno valu lar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of): Physician/Medical Examine law requires that the death certificate be executed Mostral! physician and the burial-trans resulting in death) Last Due to ( a a consequence of): O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has beer me 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 perform 2 1 No 1 □ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s after dec.
ral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 0 10 30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print) OURS NOW, SVITE # 110, ROCK STIC, 140) 208 52 31. Date filed (Month, Day) Year) State Registrar

3

Charle

mangerian,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health And Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month. Day 23 **Physician** Year MCMONAGLE 8:25 RM CATHERINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SMOCK TRAVMA CENTER BALTMORE BANTRORE If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Year) Days Months Hours Country) Pennsylvania 207-12-3680 Director October 24,1918 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director Leonardtown Maryland St. Mary's 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22680 Cedar Lane Court Apt.3407 20650 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2½ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married , o Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Lab Specialist U.S. Government 12 Health and Mental Hygidem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Palmer John Holland Ella Catherine Coghlan 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41290 Breton Beach Road Leonardtown, MD 20650 Department of Health Important; If Item 27 any injury or other troone. John McFadden / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State December 1. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Charles Memorial Gardens Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licen 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part X Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACIDOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans CAROLOGENIC resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. CAROLAMYOPATA attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FEMUR FRACTURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has the 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performed? Yes 2 2 No 1 ∐ Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this funeral 28a. Date of Injury (Month, Day, 1 10/2008 28b. Time of _Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Unknown M death. 1 □Yes 2 No FALL s after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number of Rural Route Number City or Town, State) 22680 Cedar Lane determined 4 Homicide HOME Court, Apt. 3407, Leonardtown, MD within 24 hours a 1xCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29c. License number // PI 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/23/08

State Registrar ALTWORE,

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

S. BREEN

31. Date filed (Mor

1437130184

21201

JOSEPH SHIBER

Physician/ Examiner

**Funeral** Director

any

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

rsician Medical

Examiner

Baltimore, MD 21215-0036

Director

Funeral 1

Be Completed by

2

Stephen Gerard Myers, Sr.	State of Maryland / Department of Health

Please Type or Print in Black Indelibers, Sr. State of Maryland / Department			10 3393
1- For State Certificat	te of Death	Reg. No.	
Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
Stephen Gerard Myers, Sr.		Month Day Year November 12, 2008	1402 hrs
Facility Name (if not institution, give street and number)     1720 Edinburg Lane	4b. City, Town, or Location of Dear Dunkirk	th 4c. County of Deal Calvert	h
5. Social Security Number 6. Sex 7. Age (In yrs. last birtho			rthplace (State or
217–60–6817 1X M 2 F 57	Yrs. Months Days Hours Mi	in. Forei	
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	- Location		10d. Inside City Limits
10a. State 10b. County 10c. City, Town or MD Calvert County Dunkirk			1 Yes 2 X No
10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	untry?
1720 Edinburgh Lane	20754	U.S.A.	
	13. Was Decedent of Hispanic Origin? ( & If Yes, specify Cuban, Mexican, Puer		rican Indian, Black,
3 Widowed 4 Divorced If Yes, Give Year or Date:	1 Yes 2 X No specify:		ite
dı	ecedent's Usual Occupation (Give kind or uring most of working life. DO NOT use re		/Industry
Elementary/Secondary (0-12) College (1-4 or 5+)	ome Improvement	Self-Empl	oyed
17. Father's Name (First, Middle, Last)	18.Mother's Nan	me (First, Middle, Maiden Surname)	
Frederick W. Myers	Marjor	rie J. Dent	
		r Rural Route Number, City or Town, Stat , Dunkirk, Maryland	
	Disposition (Name of cemetery, ry or other place)	DV . 17, 20c. Location - City o	r Town, State
Dullal 2 Cremation 3 Removal nom State	rn Mem. Gardens	2008 Dunkirk,	
21. Signature of Funeral Service Licensee		ee Funeral Home Cal	, i
Gary S. Coff		yland Blvd., Owings	
23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.		c or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular pue to (or as a consequence of):	al Disease		
h			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
d. UNPENDED AMENDED			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 22c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic preg	23d. Date of delive Month	ry Day Year
Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
		1 Yes 2 No 3 Pro	obably 4 🗸 Unknown
			utopsy findings available completion of cause of
		performed? death?	

26.Place of Death (Check only one)

Nursing Home 5

**OCME** 

Residence 6 🗸 Other: Scene

28f. Location (Street and Number or Rural Route Number, City

November 17, 2008

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

or Town, State)

Other₄

28c. Injury at Work?

29c. License number

O.C.M.E.

Yes 2

DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Physician/Medical Examiner

Medical Certification:

State

Registrar

3

In Inspiral or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

Theodore M. King, Jr., MD. 31. Date filed (Month, Day, 2008 8

25. Was case referred to medical

examiner?

1 V Natural

29a. Certifier (Check only one) 2

1 Yes

27. Manner of Death

Accident

Suicide

Homicide

29b. Signature and title of certifier

Assistant Medical Examiner 32. Régistrar's Signature

Inpatient

28a. Date of Injury (Month, Day, Year

and manner stated.

Hospital: 1

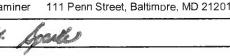
Pending

Investigation

Could not be

Name and address of person who completed cause of death (Item 23a)

determined



**ORIGINAL** 

ER/Outpatient 3

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

DHMH 17 Rev 1/2001

Helen Massey

1, Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Larkin Chase Nursing Home

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Bowie

4b. City, Town, or Location of Death

entarriyg	ICHC	100	97		- )
R	eg. No. –	100		10	J
2. Date of Deat Month	h Dav	Year	3. Time	e of D	eath

Day Year 2008

4c. County of Death

Prince George's

November

6:15 PM

**Physician** /Medical **Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Its Mydical Evartion rount by multiple at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans Division of Vital Records, P.O. Box 68760,

	5. Social Security Number	6. Sex		e (In yrs.	last birthday		er 1 Year	If Under		8. Date of Bi	rth	e)	9. Birt	thplace (State	or Foreign		
	152-18-8139	1 □ M :	2 🔼 F	90	Yrs.	Month	s Days	Hours	Min.	Nov. 26	5, $1$	917	Sou	uth Carolina			
	Usual Residence of Decedent						_'										
	10a. State 10b. Coun	ty		10c. Cit	y, Town or L	ocation								10d. Inside	City Limits		
ţ	NJ Middl	OCOV		Sou	th P1	ainf:	i o 1 d						1 <b>X</b> □Ye	s 2 No			
rec	10e. Street and Number	LESEA		500	ich Li		Zip Code				10a. C	itizen of V	Vhat Co	untrv?			
ō		. A	_				7080		USA								
ra	215 Cedarbrook																
nu	11. Marital Status	A	/as Decedent   rmed Forces?		S.   13	If Yes, sp	edent of Forecify Cuba	lispanic Or an, Mexicai	n, Puerto	pecify Yes or No- o Rican, etc.) 14. Race - American Inc Black, White, etc.							
Ā	1 X Never Married 2 ☐ Ma	lf.	☐Yes 2 1 Yes, Give	No		1 ☐ Yes	2 X No	Specify.	:			Specify	<i>r</i> :				
Q D	3 Widowed 4 Divorce	ed Y	ear or Dates:										B1	ack			
Completed by Funeral Director	15. Decede (Specify only high	ent's Education	n npleted)		(Giv	edent's Us e kind of v	vork done	durina mos	st of worl	king	16b.	Kind of Bu	usin ess/	Industry			
ם	Elementary/Secondary (0-12)		ollege (1-4or 5	i+)	`life.	DO NOT	use retire	d)		· ·							
20	12				Teste	r on	Asse	mb1y	Line	2	Wes	tern	E1e	ctric			
Be (	17. Father's Name (First, Middl	e, Last)						18. Moth	er's Nam	ne (First, Middle	, Maide	n Surnam	re)				
70 E	Joseph Massey							Josi	e Be	elle Kei	nned	У					
_	19a. Informant's Name/Relation	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State															
					215	Codo	rhwaa	1. Arro	7110	South 1	ว1 กร์	nfio	1.4	NT 070	80		
		Barbara Cooke-Niece 215 Cedarbrook Avenue South Plainfield,  20a. Method of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)															
	1 X Burial 2 ☐ Cremation	n 3 ☐ Remov	val from State	C	emetery, cr	ematory o	r other plac							,			
	4 □ Donation 5 □ Other			Hob	oken					21/2008	1						
	21. Signature of Funeral Service	e Licensee								ert E.					e		
	alle &	we				16000	0 Ann	apoli	s Ro	oad Bow:	ie,	MD 20	0715	·			
	23a. Part 1. Enter the disease, shock, or heart failure. Li	or complication	ns that caused	the deat	h. Do not e	nter the m	ode of dyir	ng, such as	cardiac	or respiratory	arrest,			Approxima Interval B	ate etween		
	Immediate Cause (Final	st only one car	use on each in	. 4	100	0	0.0	2	-					Onset and			
	disease or condition resulting in death)	a	1eta		Atic	D	rea	1)1	Ca	man			-	Jean	4		
			Due to (or as	a conseq	uence or):									1			
_	Sequentially list conditions, if any, leading to immediate	b	ven		14									yea	~S_		
ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.																
am	that initiated events c. resulting in death) Last Due to (or as a consequence of):																
<u> </u>	resulting in death) cast	1	Due to (or as	a conseq	uence ot):												
ica		d															
led													i				
Ę	IF FEMALE: 23b. Was decedent pregnant		yes, outcome			□ Fatani						23d. Da	te of de	livery			
cia	in the past 12 months? 1 ☐ Yes 2 ☑ No.	4	Live birth Pregnant a			Ectopid ☐ Other (						Mo	nth	Day	Year		
ıysı	9 Unknown	9	Unknown														
ᆸ	Part II. Other significant cond	tions contribu	ting to death b	ut not res	ulting in the	underlying	g cause giv	en in Part	I.	23e. Did	tobacco	use cont	ribute to	the cause of	death?		
ğ	Hyperbara	thyn	pidi	Smi						1 🗆	Yes	2 <b>X</b> No	3 □ Pi	robably 4	Unknown		
iec	JA	-	DI-CI	S) - (								1					
풡										24a. Was		24b.	Were au	utopsy finding completion of	s available cause of		
PO										perf 1 □ Yes	ormed?		death?	2 □ No			
e C	25. Was case referred to medic	al		_				26. Place	e of Dea	th (Check only							
0	examiner? 1 ☐ Yes 2 ☑ No	Hospit	tal:	ent 2	ER/Outpati	ent 3 🗆	DOA Oth	er: 4 🗀	ursina H	ome 5 ☐ Res	idence	6 □Oth	er (Sne	cify)			
Ë	27. Manner of Death	28	Ba. Date of Inju	iry	28b. Time	of	28c. Inju	y at	uronig i i	28d. Describe				ony/			
Ę.	1 Natural 5 Pend 2 Accident inves	ling stigation	(Month, Da	y, Year)	Injury	М	Wor	k? Yes 2□	No			-					
ca	3 ☐ Suicide 6 ☐ Coul	d not be	Be. Place of Inj	urv - At bo	ome farm s	treet facts				28f Location	(Stroot	and Numb	ar or Pi	umi Poute Ni	mhar		
E	4 ☐ Homicide dete	rmined 20	building, et	c. (Specif	<i>y</i> )	,, ooi, lacii	ory, onice			28f. Location City or To	wn, Sta	te)	ei vi Al	arai i ioute ivu	muer,		
ပိ				, .													
cal	(Check only 2 Medic	ai Examiner:	On the basis o	f examina	wiedge, dea ation and/or	ath occurre investigati	ed at the ti on, in my o	me, date a opinion, de	ath occu	e, and due to the	e cause , date a	<li>(s) and mand and place.</li>	anner a: and due	s stated. e to the cause	(s)		
Medical Certification: To Be Completed by Physician/Medical Examiner	one)		and manner sta							1	-						
2	29b. Signature and title of certil		Δ.		MA	2	29c. Licens		i ~	62		, -		h, Day, Year)			
	* Ka Kes	no	ndlo	7 1	$\sim$ 1)	-	D	20	10	8	- 1	1117	110	108			

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Registrar

AKESH

31. Date filed (Month, Day, Year)

ORIGINAL

MI) 14300 GALLANT FOX LN#22L BOWIE MD 20715

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 20, 2008 7:10 a.m. Malcolm Vivien Morris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 □ F Yrs. Director 219-16-5061 85 June 21,1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Director Maryland| St. Mary's <u>Leonardtown</u> 10e. Street and Number 10g. Citizen of What Country? 21692 Point Lookout Road 20650 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married er than "natural", or 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Storer Miles Morris Helen Pussler Agnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. 21692 Point Lookout Road, Leonardtown, MD 20650 Charlotte L. Morris/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 11/26/2008 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01206 22955 Hollywood Road, Leonardtown, MD 20650 Kyle Simons 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ance disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on burial-tran Due to (or as a consequence of): sate has been signed by the attending physiclan page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 3 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate funeral director, page 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Box 68760, P.0. Records, Division of Vital

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital of within 24 hours a To the Funeral D

Medical

(Check only one)

29b. Signature a

James P. Jarboe filed (Month, Day, Year) 31. Date filed (M 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

title of certifier

gistrar's Signature

Leonardtown, Maryland 20650

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

5 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0732 Caroline Morris 11 22 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner albot astol Memoria toppita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 16 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 💢 F 1934 74 Director 218-80-4462 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d, Inside City Limits than "natural", or Items 23a or 28a-f show 1 Yes 2 □ No Directo Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Caroline Ave. 21660 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 🗓 No White 2 Specify: 3 X Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Jester Georgianna Hutson Jester ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Department of Health Important: If item 27 any injury or other tronce. 27 Mary Jane Irwin/ daughter PO Box 147; Ridgely, Maryland 21660 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crema Cn Dec. 13 2008 Chester, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, MD 21639 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** dema Tulmonary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Infections Post The law requires that the death certificate be executed Glomerulo helphritis attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ ulmonar Obstructive 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2/ No 1 ☐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 27. Mapner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by

Registrar DHMH 17 Rev 1/2001

24 hours a

within 2

completely

4 - Homicide

(Check only one)

29b. Signature and thie of dertifier

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 200

an D

20

29a. Certifier

Medical

State

5,

219 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D5448 8 29d. Date signed (Month, Day, Year)

Washington St, Easton. MB 21601

11-22-2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Year **Physician** Charles Adam Mann 12:10 p ^M November 17, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours Days Country)
Maryland 1 M 2 □ F 86 Jun 8, 213-14-9181 Director Usual Residence of Decedent the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a State Carroll Westminster 1 ☐ Yes 2 X No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 740 Old Baltimore Road 21157 USA items 23a 'natural', or items 23a dical Examiner must I Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Petroleum permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: If Item 27 is marked other the any Injury or other traumatic event, the I once. Truck Driver the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry H. Mann, Sr. Agnes A. Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 740 Old Baltimore Road, Westminster, MD 21157 19a. Informant's Name/Relationship (Type. Print) Thelma D. Mann, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sandymount U M Cem 11/23/2008 Finksburg, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 21. Signature of Funeral Service Licens uter 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequer 24 of): **Examiner** rlensin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a consequence of) requires that the death certificate be executed and burial-tran Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. the detached 9□Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an The law has page 2 autopsy certificate 1∐ Yes 2 No or Vital 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Division or Attending 5 Pending investigation Injury within 24 hours area community.

To the Funeral Director: Aff 1 Tyes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier t 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 1 D74 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Middletonin 31. Date filed (Month, Day, Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Mischler 11 9:00 A M 18 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1000 N. Schumaker Drive Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F Director 91 9-18-1916 142-07-5100 Connecticut Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Madical Examinar roust be notified at 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 North Schumaker Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2X No Specify: If Yes, Give Year or Dates: Specify: White 3Ã Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Health Food Store permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny july or other traumatic event one: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ William Wagstaff Eva 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07711 19a. Informant's Name/Relationship (Type, Print) Walter Mischler - Son 714 Palmer Avenue, West, Allenhurst, New Jersey 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 🎇 Removal from State West Long Branch 4 ☐ Donation 5 ☐ Other (Specify) 11-21-2008 New Jersey Glenwood Cemetery 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Fundral Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 23a. Pa.rl. Enter the disease, or complete in a sthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ue to (or se a consequence of): Examiner signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 🔲 No To the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manney of Death Certification: 28d. Describe how injury occurred 1-Natural 5 Pending Injury death investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 🚅 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie? 29d. Date signed (Month, Day, Year) 11/10 9-12000 address of perspn who completed gluse of death (Item 23a) (Type, Print) 30. Name an 1746 9 C D.v rah 32. Redstrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 9 2008 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Ruth H. Nusbaum November 14, 2008 6:45 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Alfred House 8. Date of Birth (Month, Day, If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 □ F 1911 97 118-03-9546 May 31, New York Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1√TYes 2□No MD Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 907 Glaizewood Avenue 20912 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2⊠No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Meyer Freedman Anna Kaplan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 907 Glaizewood Ave, Takoma Park, MD 20912 Fern G. Garofald, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State National Crematorium 11/19/2008 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Congestive Heart Failure disease or condition resulting in death) month Due to (or as a consequence of): Dementia of Alzheimers Type years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 🕱 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perforn 2**₹** No 1∏Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 In Nursing Home 5 In Residence 6 Mother (Specify) Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation t ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25410 November 17, 2008 Lu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oliver Lawless, MD, 18111 Prince Philip Drive, Olney, Maryland 20832 Suite 202 31. Date filed (Month, Day, Year) 32 Registrar's Signature VON 19 2008

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Registrar  Certificate of Death Registrar  1. Decedent's Name (First, Middle, Last)  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VIRGINIA PERKINS  ADELAIDE VI
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21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE.P.A.
RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646
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29a. Certifier  29a. Certifier  29a. Certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Pay, Year)

State Registrar

DHMH 17 Rev 1/2001



20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 6- Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician**  $\underline{A}^{\,\mathsf{M}}$ 2008 Parshewski 08:58 Ludmilla November 17. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Frederick Calvert Calvert County Nursing Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 👿 F 87 Ukraine May 31, 1921 Director 165-26-9952 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ▼Yes 2 No Director Prince Frederick Maryland 1 4 1 Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 20678 United States 85 Hospital Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: White à 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filed wirtment of Health and Mental Hygien tant; If item 27 is marked other the jury or other traumatic event, the Geologist Russian Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dora Breslavic Jakob Kushnariw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8268 Greenspring Drive, Chesapeake Beach, MD 20732 Stanley Parshewski / Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory, or other of Chesapeake Highlands Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/22/2008 | Port Republic, Maryland 22. Name and Address of Facility Rausch Funeral Home, P.A. 21 Sanatos of Funeral Service Nicenses lacel 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION **Physician** MYSCARDIAL /Medical Due to (or as a consequence of): Examiner ORENARY ARTERY DISERSE sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed CONGESTIVE HEART FAILURE and burial-trai Due to (or as a consequence of) Box 68760 physician Physician/Medical the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Vo for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has page 2 autopsy 1□ Yes Vital Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only ofie) Be 70 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1. Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident death 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Hospital

DRW 3

within 2

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Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day

29b. Signature and title of certifier

Registrar

and manner stated.

MO

. Registr s Signature

2008 Re

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0233

110 HOSPITAL DR, #310 PRINCE FREDERIKK, MD

29d. Date signed (Month, Day, Year)

Physic /Medi Exami

Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 10

	1 - For State Registrar	State of Ma	Tyland / L	•	tificate of L		אווע ועוכ	, ,	greri Reg. N	1:17 7	8	385	192		
	1. Decedent's Name (First, Middle, Last)						2	2. Date of Dea		av Ye		3. Time of	Death		
an cal	Wilma A. Lester	Pickard					N	lov. 17	, 2	008 ^{Ye}	aı	7:15E	) M		
ıer	4a. Facility Name (If not institution, give si	treet and number)			4b. City, Town, or		of Death			c. County of D					
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Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ∭XNo If Yes, Give Year or Dates:	0	1	□Yes 2XNo	Specify:	Specify: W	_{ecify:} White							
etec	15. Decedent's Educi (Specify only highest grade	ation completed)	16a	Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation Juring most	of working	,	16b. l	Kind of Busine	ss/Ind	lustry			
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ပို	17. Father's Name (First, Middle, Last)		56	што	I Financi			First, Middle,				30 4 6 1 111	nene.		
To B	Will H. Lester					Eff	ie M.	Carro	11						
-	19a. Informant's Name/Relationship (Typ	pe. Print)	19b	. Mailin	g Address (Street	and Numbe	er or Rural	Route Numbe	r, City	or Town, Stat	e, Zip	Code)			
	Richard Stepakof	POA	9	416	Holbrook	Lane	Po	otomac,	MI	2085					
	20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Rock Creek Cemetery 11/20/2008 Washington														
	4 Donation 5 Other (Specify)	smovar from State	Rock							shingto					
	21. Signature of Funeral Service Licenses	е			. Name and Addres										
H	230 Part 1 Enter the distance or complia	ration that assumed to	ho dooth Do	5	130 Wisco	onsin	Ave.	, NW W.	ash	ington	D				
	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final					g, such as	carulac or	respiratory ar	rest,			Approximate Interval Betw Onset and D	eath		
	disease or condition resulting in death)	. Myocar Due to (or as a	dial Ir		ction						1	0 Minu	tes		
			Year												
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	+		5											
ami	Cause (Disease or injury that initiated events c. resulting in death) Last	Multio Due to (or as a	rgan Fa		re						$\downarrow$	Mont	hs		
E E	resulting in deathy East														
Aedical Examiner	Ö d														
Z.	IF FEMALE: 23b. Was decedent pregnant	delive	ry												
Completed by Physician/N	in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown			Ectopic pregnancy   Other <i>(specify)</i>	<i>'</i>				Month	•				
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ı.	27. Manner of Death	28a. Date of Injury (Month, Day,	/ 28b.	Time of njury	28c. Injury Work	/ at		d. Describe h		•	pecny	7			
atic	1 Natural 5 Pending 2 Accident investigation	(	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,,		res 2□N	No						_		
ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, fa (Specify)	rm, stre	et, factory, office		28	3f. Location (Street and Number or Rural Route Number, City or Town, State)					ber,		
Medical Certification: To Be	29a. Certifier 1	ician: To the best of her: On the basis of and manner state	examination ar	e, death	occurred at the tir restigation, in my o	ne, date an pinion, deal	d place, ar th occurred	nd due to the	cause(	s) and manne	r as st	tated. the cause(s)			
Me	29b. Signature and title of certifier	) P.	Λ.		29c. License				29d. D	ate signed (M	onth, L	Day, Year)			
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	30. Name and address of person who con														
	Raman R. Tuli MD 1 31. Date filed (Month, Day, Year)	.0810 Darn	estown	Rd.	#202 Ga	ither	sburg	, MD	208	378	_				
ite ar	NOV 1 9 2008			600	de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya della companya della companya de la companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della companya della										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 **Physician** Month Nov. 15. Mary-Jane Pates 11:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bartholomew House Bethesda Montgomery 9. Birthplace (State or Foreign Country) Washington, DC If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year Dec. 12, 1 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F 578 24 5799 87 1920 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2□No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7504 Glenriddle Road 20817 United States Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph John Love, Jr. Jane Ruth Groome ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Jeffrey Pates/Son 7504 Glenriddle Road Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of Important: If its
any Injury or o 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State National Crematory 11/17/2008 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licensee uncu 5130 Wisconsin Ave., NW Washington, DC 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Cancer **Physician** Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔯 Unknown Completed Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a, Was an autopsy 2 🖾 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 XNatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760, signed by the a Division of Vital Records, P.O. been si should I certificate has tirector, page 2 s this After ours after death.

leral Director: A
filled in by the fu ò

director, Certification: To funeral

Medical

29a. Certifier

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with t nent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. Intil filem 27 is marked other than "natural", or items 23a or intil filem 27 is marked other than "natural", and not other traumatic event, the Medical Examination and or other traumatic event, the Medical Examination and the statement of the process.

Baltimore, Maryland 21215-0036

the

5 Pending investigation 2 Accident 3 ☐ Suicide 4 Homicide

6 ☐ Could not be

and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐Yes 2 ☐No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifie

D33357

29c. License number

29d. Date signed (Month, Day, Year)

11/17/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Lee Muscher MD 5530 Wisconsin Ave. #1045 Chevy Chase, MD 31. Date filed (Month, Day, Year)

State Registrar



24 hours a

To the within 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 15 NOVEMBER 2008 Juan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT AGNES HOSPITAL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** 1 □ M 2 🗓 F Months 225-01-0831 Director 90 May 24,1918 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location fshow 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Prodical Examinar must be notified at Director 1 XYes 2 No Baltimore Catonsville Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 707 Maiden Choice Lane #8G18 U.S.A. within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No 2 Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Charles Columbus Owen Beulah Pickeral ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an James O. Emerson / Son 600 Moonglow Rd.#304 Odenton, Md. 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of t Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park Nov.20,2008 Rockville, Maryland 21. Signature of Foneral Service Licenses 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N .W. Wash. D.C. 20007 Kuli 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART PALLUPF years /Medical Due to (or as a consequence of): Examiner Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last years Examiner Due to (or as a consequence of): that the death certificate be execut and buriat-trar Due to (or as a consequence of):  $\rho_{ARIS}$ , RubyDivision of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? The law requires FIBRILLATION 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has briector, page 2 st autopsy 2 No 1 □ Yes 1 □ Yes 2 🗆 No Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 124 hours after death.

Ne Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

To the I

State Registrar 31. Date filed (*Month*, *Day*, *Year*) **NOV** 1 9 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P 2161

BALTINICZE

NEVEN BER 16, 2008

08-08567 Donald Pfeifer

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-	1	10		-1	1

		I- For State Registrar	Cert	tificate of	Death		Reg	g. No.				
Physicia Iedical Exami	an/	1. Decedent's Name (First, Middle, Donald Earl P	feifer, Sr.				November	Day Year 15, 2008	3. Time of Death 1541 hrs			
		4a. Facility Name (if not institution, Prince Georges Hospita		4	b. City, Town, or Cheverly	Location of Deat	h	4c. County of Dea				
Funeral			. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year	r If Under 24Hr	s. 8. Date of Birth	(MM/DD/YYYY) 9. E	Birthplace (State or			
Director		579–38–7476  Usual Residence of Decedent	X M 2 F 79	Yrs.	Months Days	s Hours Mi	Dec. 1	7, 1928 W	ashington, DC			
any		10a. State 10b. County	Co. 10c. City, 1	Town or Locati	on				10d. Inside City Limits			
faryland 28a-f show 1 at once.	ō	MD Prince		oer Mar					1 Yes 2 X No			
Maryl r 28a-	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?			
ith the Maryland 23a or 28a-f she notified at once		10602 Kaine Pla		140.14/-	20774		Smarlf : Var an Na	U.S.A.	erican Indian, Black,			
21215-0036 Uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divor	12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No ced If Yes, Give Year	If Y	es, specify Cuban	, Mexican, Puert	Specify Yes or No- o Rican, etc.)	White, etc.				
urs aft	d by	15. Decedent's Education (Specif	or Dates:	16a. Deceden	t's Usual Occupat	ion (Give kind of		16b. Kind of Busines				
<b>336</b> thin 72 hours a. ne. than "natural edical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working life.	. DO NOT use re	tired)					
003 within iene. or tha	dmc	12	+2	Corpor	ate Safe			Utility (	Company			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, L. Frank Pfeifer	ast)			Alice	ne (First, Middle, M Rrown	laiden Surname)				
2121 ould be fi Mental marked		19a. Informant's Name/Relationship	(Type, Print )	19b. Mailing	Address (Stree			ber, City or Town, Sta	r, City or Town, State, Zip Code)			
fmore, MD 2121 Pages I and 2 should be fit nent of Health and Mental lant: If item 27 is marked or other traumatic event,	İ	Louise Y. Pfeife						boro, MD 2				
ore, Mes I and 2 of Health If item 2		20a. Method of Disposition  1 Burial 2 Cremation		lace of Dispos rematory or oth	ition (Name of cer ner place)	metery, No	v. 19,	20c. Location - City	or Town, State			
Page Page ment c		4 Donation 5 Other Spe			lem. Gard	dens	2008	Dunkirk,				
Baltimore, permit. Pages I an Department of Hea Important: If iter		21. Signature of Fund 1999 Li	24						lvert, P.A.			
Physician	-	23a. Part I. Enter the disease, or co	omplications that caused the death.						gs, MD 20736 Approximate Interval			
/Medical		failure. List only one cause or Immediate Cause (Final disease	n each line. a. Hypertensive Atheroscle						Between Onset and Death			
xaminer		or condition resulting in death)	Due to (or as a consequence of)									
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b	).								
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	C									
vecuted 1 and - transit		events resulting in death) Last	Due to (or as a consequence of)	):								
9 B B	/Medical	UNPENDED	AMENDED									
760, icate be sphysici the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn	nancy		23d. Date of delivery  Month Day Year						
Box 68' death certiff he attending of for use as		past 12 months?	1 Live birth 4 Pregnant at time of dea	2 Fe ath 5 Ot	nancy Month Day Yea							
BOX e death the atte	Physiciar	1 Yes 2 No 9 Unknown	own g Unknown									
P.O. B es that the d gned by the	by Pi	1	ns contributing to death but not re		23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown							
S, P.C uires that an signed Id be deta	ed b	Chronic Alcoholism										
cords, law requii has been s 2 should	Pet						24a. Was a autops perfor	sy prior t	autopsy findings available o completion of cause of			
tal Rec cian: The l certificate b	Completed						1 ✔ Yes 2					
ital fician:	å	25. Was case referred to medical examiner?	Hospital:	EB/Outpotiont		Other Nurs		Residence 6 Ot	ner:			
ion of Vital Records, tending Physician: The law requirienth. Icath. Ior: After this certificate has been si, the funeral director, page 2 should b.	P.	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of I		ry at Work?		ow injury occurred	ner.			
_ = _ ` =	ţį	1 V Natural 5 Pendin			1	Yes 2 No						
Division tal or Attendi rs after death. at Directors //	ifica	2 Accident Investig	28e. Place of Injury - At ho	me, farm, stree	et, factory, office b	ouilding, etc.			Rural Route Number, City			
E 8 5 E	Certification:	4 Homicide determ					or Town, St					
llos 24 h Fun tely			sician: To the best of my knowledg iner:On the basis of examination an									
To the within To the comple	Medical	29b Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (/				
		( ) culit	2.11/1		O.C.			November 16,				
		30. Name and address of person w	ho completed cause of death (Item	23a)								
RW 5+1			sistant Medical Examiner		Street, Baltir	more, MD 21	201					
St	ate	31. Date filed (Month, Pay, Year)	32. Registrar's Signatur	K A	ast s							
Regist	પાર્ટી		Lacorner 1	~ 6	San San San San San San San San San San							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month NOV. Day **Physician** Leroy Pittman, Jr. 24, 2008 2:20 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mallard Bay Cambridge Dorchester 8. Date of Birth (Month, Day, Year) 9, 1962 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 222-56-5859 Days Hours Delaware 46 Yrs. Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marn Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shany injury or other traumatic event, the Medical Examiner must be notified a once. MD Dorchester 1 ☐ Yes 2 ☐ No Director Hurlock 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4226 East New Market Road 21643 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🗓 No ģ Specify: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Fork Lift Operator & G Foods 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Pittman, Sr. Betty Dennis ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teshonda Thomas/Companion Post Office Box 72, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Federal Hill Cem. 12/01/08 Federalsburg, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee heloale CFSP 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each liqe. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed use as the burial-tran and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Vear 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 has autopsy performed? Yes 2.2 No certificate 1∐ Yes Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Year) 2 6 2008

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HTER , Registrar's Signature

503

DHMH 17 Rev 1/2001

Stut, Combaidge, MD-21613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Samuel Phillips State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day November 29, 2008 1120 hrs Medical Examiner **Phillips** Samuel Paul 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) McCoole Allegany 25125 Marsh Manor Court 8. Oate of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. **Funeral** oreian Hours Director Apr 9, 1964 CountryPA 1 X M 2 F 197-48-8744 44 Usual Residence of Decedent 10c. City, Town or Location
Westernport 10d. Inside City Limits 10a, State 10b, Count MD Allegany Yes 2 X No 23a or 28a-f show notified at once. with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25125 Marsh Manor Court 21562 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) leath 1 X Never Married 2 Married Specify: white Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after nent of Heath and Mental Hygone. ant: If item 27 is marked other than "natural", or orther tranmatic event, the Medical Examineer. Widowed Divorced If Yes, Give Year þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 electrician Electrial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Phillips Helen Phillips 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21562 Westernport John Arlott Sr. brother 404 Vine Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, Burial 2 X Cremation 3 Removal from State 12/1/2008 Cresaptown MD Scarpelli Funeral Home, P.A. Donation 5 Other Specify: 21. Signature of Funeral Strvice Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA tomplic trons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart on each line. Approximate Interva 23a. Part I. Enter the disease, or contailure. List only one cause of Physician Between Onset and Death /Medical a Mixed drug (Sertaline, trazodone) Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death), Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical 23a,2/,28a-f, per mE G886 12/9/08 TT X UNPENDED the attending physician ed for use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year past 12 months Pregnant at time of death 5 Other (Specify) Yes 2 No 9 F Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an has been autopsy prior to completion of cause of performed? death? page ✓ Yes 2 2 No ✓ Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other₄ DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 Residence 6 V Other: Scene this 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: n 24 hours after death
e Funeral Director: A
letely filled in by the fu Natural Yes 2X No unk Pending Fd 11/29/08 Fd 9:30 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City, or Town, State) 25125 Marsh Manor C 3 6 X Could not be Suicide found in dwelling determined MDMcCoole, 29a. Certifier completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME November 30, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

State

31. Date filed (Month, Day

2008

32. Registrar's Signature

	-	State Registrar				(	Certific	cate of	Death	1		Re	g. No.	211	18	333	
Physicia	ın	1. Decedent's Name (First, M. Jane Gilc	liddle, Las Christ		enbury	7					2. Date of Month Nove			- 2		3. Time of Death	
/Medica	al 🦫						Alb	City Town 0	r I conting	of Dooth	Nove	m De		ounty of		4:30a N	
Examine	er	4a. Facility Name (If not instituted Collington					40.	City, Town, or Mitch			Geor	ges					
uneral		5. Social Security Number 579–16–2405	n yrs. last birth	Mor	nder 1 Year nths Days	If Unde Hours	Min.	8. Date o	f Birth , Day,	Year)		9. Birthplace Country)	e (State or Forei				
irector	9	Usual Residence of Decedent		□M 2×C3×F	93	γ γ	rs.				June	6,	191	5	North	Carolin	
ow	ŀ	10a, State 10b. Cou			10	Dc. City, Town	or Location	ı							10d.	Inside City Limi	
a-f sh ifled	tor	M D Prin	nce G	Seorges	IV.		С	apito1	Heigh	nts		1 <b>x∃x</b> es 2 □ No					
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number				_	10	f. Zip Code				-	-		at Country?	?	
s 23a		411 Saint N	M arga			- i= II C	40.14/ 5	20743		1.1-0.40	-16 16		United States  14. Race - American Indian,				
iner	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ N	Married	12. Was Ded Armed F 1 □ Yes	orces?	1110.3.	If Yes	ecedent of H specify Cuba	)	Black, White, etc.							
Exam	þ	3 Widowed 4 □ Divor		If Yes, G Year or I	2 No live Dates:		1 □ Y	es 2Mo	Specify		Specify: Afro-American						
dical	Completed	15. Dece (Specify only hi	edent's Ed	ucation de completed	")	3 (	Give kind of	Usual Occup	durina mo	st of work	ng	1	16b. Kind of Business/Industry				
e Me	mp	Elementary/Secondary (0-1 12th			(1-4or 5+)			OT use retired <b>tician</b>	d) -			F	'ede	ral (	Govern	nment	
int, th	ပ္တိ	17. Father's Name (First, Mid	idle, Last)						18. Moth	er's Name	(First, Mic	ddle, M	dle, Maiden Surname)				
ic eve	To Be	Thomas	Gil	christ						Lela	Mc	Canı	n	,			
nmat		19a. Informant's Name/Relati				19b.	Mailing Add	iress (Street	and Numi	er or Rur	al Route N	umber,	City or	Town, St	tate, Zip Co	de)	
her tra		Gloria M. I				rgare		., Capitol Heights, MD 20									
or oth		20a. Method of Disposition 1 ★Burial 2 ☐ Cremati	ion 3 🗆	Removal from		20b. Place of I cemetery	Disposition , cremator	(Name of or other plac	ce)		ate				ity or Town,		
Jury		4 □ Donation 5 □ Othe		<u></u>		Fort L	Lincoln Cemetery 11/21/2008 Brentwood, MD  22. Name and Address of Facility McGuire Funeral Service, Ir										
any l		21. Signature of Funeral Serv	vice Licen	9ee 	1 ₀ /	,										, Inc. C 20012	
200		23a. Part1. Enter the disease shock, or heart failure.	e, or comp	olications that	caused the	e death. Do no						_		mige		proximate erval Between	
cian		Immediate Cause (Final	List only			e to Th		·							Or	nset and Death	
dical		disease or condition resulting in death)		a		onsequence of									21	nonths	
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as the	/Medical			. C													
		IF FEMALE: 23b. Was decedent pregnant	t	23c. If yes, or		oregnancy Fetal death	death 3 ☐ Ectopic pregnancy						23d. Date of deli				
ed for u	sicia	in the past 12 months? 1 ☐ Yes 2€ X No			gnant at tim	ne of death						_		Monti	h Day	y Year	
etach	Physiciar	9 ☐ Unknown  Part II. Other significant con	dialogo		-414: 1	Mara a consideration		220 Did tahaasa uga cantributa ta tha causa									
p eq l	۾	Part II. Other significant con	iditions co	ontributing to t	ot resulting in	ine undeny	23e. Did tobacco use contribute to the cause of										
should	eted											3 Probably 4 □Unknow					
ge 2 s	Completed								8	Vas an autopsy perform	.	prie	ere autopsy or to comple ath?	findings availal etion of cause o			
or, pa		25. Was case referred to med	dieal						1  Y	es 2	No		Yes 2	] No			
ral director, page 2	Be	examiner?  1 Yes 2 No	H	Hospital: 1 [	Inpatient	2   ER/Out	natient 3F	DOA Oth	er:		Check o				(Oit-)		
eralo	n: To	27. Manner of Death		28a. Date	of Injury	28b. Ti	me of	28c. Injur Wor			me 5□F 28d. Descr				. , , , , ,		
un e fun	atio	Z LI Accident	estigation		nth, Day Ye	ear) inj	jury M		K? Yes 2□	]No							
by #	Certification:		uld not be termined	Zee. Plac	e of injury	- At home, farr Specify)	m, street, fa	ctory, office			28f. Locatio	on (Stre	et and	Number	or Rural Ro	oute Number,	
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To the Funeral briegory. After this certaincale has been signed by the arter completely filled in by the funeral director, page 2 should be detached for u.	Medical	29a. Certifier 1X Certi (Check only one) 2 Medi	ifying Phy ical Exam	niner: On the	basis of ex-	ny knowledge, amination and	death occu /or investig	rred at the tir ation, in my c	me, date a opinion, de	nd place, ath occur	and due to ed at the t	the ca ime, da	use(s) a te and p	nd manr blace, an	ner as state d due to the	d. e cause(s)	
omple	Med	29b. Signature and title of cer	rtifier	and mai	nner stated			29c. License	e number			29	d. Date	signed /	Month, Day	/ Year)	
8		•	//	111115	-	÷		114	76	03			1//	11/	ch.	, roar,	
	-	30. Name and address of per	rson who o	completed cau	use of death	n (Item 23a) /T	vpe. Print)	VI	100				11/	-			
		remine and addition of her			J. Jouli	( =50) (1	, p=) . mik)										
		William F. I	DuBo	yce, M	D	12158	Centr	al Auro	nuc	Mitch	ellwi	۱۵	MD	20	721		
State	te	William F. I 31. Date filed (Month, Day, You NOV 1		32	D Registrar's		Centr	al Ave	nue,	Mitcl	ıellvil	le,	MD	20	721		

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Physic		1.	gistrar Decedent's Name (First,								-11	2.	Date of De Month	eath Day er 23, 200	Year		Time of Death 0942 hrs	
Exam	nine	1	Margari  a. Facility Name (if not ins	to dive	Hidal		Rami	irez  4b	. City, Tov	vn, or Lo	cation of		Novemb		unty of D	eath		
		40	3319 East Baltimo			,			Baltimo	re	- 45							
Funera		5.	Social Security Number	6. Sex		7. Age (In yrs	. last birth	day)	If Under	1 Year Days	If Under Hours	24Hrs. Min.		Birth (MM/DD/	I.E.	oreign <b>M</b>	exico	
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any		_	sual Residence of Decederate  Da. State 10b. Co				ty, Town o										d. Inside City L	
*			MD			Ва	ltir	nore	<u> </u>								XYes 2	No
tarylan 1888-f S	Director	1	0e. Street and Number						10f. Zip C					10g. Citizen			?	
tith the Maryland 23a or 28a-f show	ءً ا	_!	3340 East	Balt		e Stre		13 W/ac		of Hispa		n? (Spe	cify Yes or I		Race - A		Indian, Black,	
ath with	Finnera		Marital Status     X Never Married 2	Married	Armed F			If Ye	s, specify	Cuban, I	Mexican,	Puerto R	ican, etc.)		White, e		hite	
fter de		ا ۱	3 Widowed 4		If Yes, Give Yes	ır			Yes 2		specify:				ecify:			
lours a	15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bus																	
36 in 72 h	Carpenter 12														ruc	tion		
5-0036 iled within 7. Hygiene.		<u></u>	7. Father's Name (First, M	Middle, Last)						18							alan	
1215 be file ental H	Vent, I	19a Informant's Name/Relationship (Type, Print hrother 19b. Mailing Address (Street and Number of Rulai Route Norther)																
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fate	natic e		_{9a. Informant's Name/Re} Joaquin Hi											ceet :	Balt	imo	re, Md	
P P E	traun	1	20a Method of Disposition	1 -		20	b. Place o	of Disposi	tion (Name er place)	e of cem		10/	Date				wn, State	
S 50 =	r other		1 X Burial 2 Cre 4 Donation 5 Of		Removal f	rom State	Cem		repe ry					l			exico	
Baltimore, permit Pages I a Department of He Important: If ite	injury o	7	21. Signeture of Funeral S	ervice Ucen	see 1			PHM	Pre Pre	Address	RINA mbia	LDI	FUN	ERAL	SER	VICE	E,P.A. ,Md20	910
,		4	23a. Part I. Enter the dise	ase, or comp	lications that	caused the de	ath. Do no	ot enter th	ne mode of	f dying, s	such as c	ardiac or	respiratory	arrest, shock	c, or hear	1	Approximate I Between Ons	nterval
hysicia ledic		1	failure. List only one Immediate Cause (Final d	cause on ea	ich line.	c arrh											Death	
∟xamine	er		or condition resulting in d	eath)	Due to (or as	a consequenc	e of):											
			Sequentially list condition if any, leading to immedia	15,		megaly a consequence		_				-						
	١.	틸	cause. Enter Underlying (Disease or injury that init	Cause c.	Due to (or as	a consequenc	ce of):									-		
nted d	ansit	EX	events resulting in death)	) Last d.								- 01	26 10	/11/00	mm.			
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and	rial - tr	Medical	X UNPENDED		AMENDED	PI lin	e a-l	b, P:	II,27	, pe	er MH	€ g88	36 12/					
760, icate be	the bu		IF FEMALE: 23b. Was decedent pregn	ant in the		, outcome of p			tal death	3	Ectopi	c pregna	ncy		Date of o	Da	y Ye	ear
Box 687 e death certiffor the attending p	I director, page 2 should be detached for use as the	Physician/	past 12 months?		4 Preg	nant at time o	C de edle	-	ther (Spec	cify)				-				
BO)	hed for	Syl-	1 Yes 2 No 9 Part II. Other significant		3 Olik	to death but r	not resultir	ng in the u	underlying	cause g	jiven in P	art I.	23e. D	oid tobacco u	se contri	bute to th	e cause of dea	ath?
of Vital Records, P.O. ng Physician: The law requires that the law tentificate has been signed by	e detac	ক্র	Chronic a										1	Yes 2			bly 4 🗸 Uni	
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SCOF le law 1	ge 2 sh	dmo												erformed? 'es 2 No		eath? Yes	2	No
II Re	tor, pa	S B	25. Was case referred to								of Death		only one)	r=-1		<b>a</b> pu		
Vita hysicia this ce	al direc	10 B		No	Hospital: 1	Inpatient 2		Outpatien  Time of			ry at Wor		g Home 5	ribe how injur	ry occurr		Scene	
_ = ~	fune		27. Manner of Death  1 X Natural 5	Pending	28a. Da (Moi	te of Injury nth, Day,Year)	200.	. Time or	11,019	100000	Yes 2							
ision	by the	icati	2 Accident	Investiga	28e. Pl	ace of Injury -	At home,	farm, stre	et, factory	, office b	ouilding, e	etc.	28f. Locat	ion (Street ar	nd Numbe	er or Rur	al Route Numb	per, City
Hespital or Attending the hours after death.	filled in by	Certification:	3 Suicide 6 Homicide	Could no determine	ed (Specia													
- 3	completely fi		29a. Certifier (Check only one) Certifier Media	ifying Physical Examina	cian: To the b	est of my kno	wledge, de	eath occu	urred at the ation, in my	e time, da y opinior	ate and p	lace, and	d due to the at the time,	cause(s) and date and place	d manner ce, and d	as state lue to the	d. cause(s)	
To the within 2	comp	Medical	29b. Signature and title of		and manne	r stated.					se numbe						th, Day, Year)	
			South 1	Leville.	11 MA					O.C.	M.E.			Nov	ember	24, 20	08	
			30. Name and address of		completed c	ause of death	(Item 23a	)	44 D==	C#	t Delt:	more	MD 2120	11				
			Pamela E. Sout			nt Medical Registrar's Si		er 1	11 Penr	i Stree	t, paill	more, I	MD 2120					
Re	Sta gist	ate rar	31. Date filed Month Da	0°1"20	08	Riber	B	And	1									